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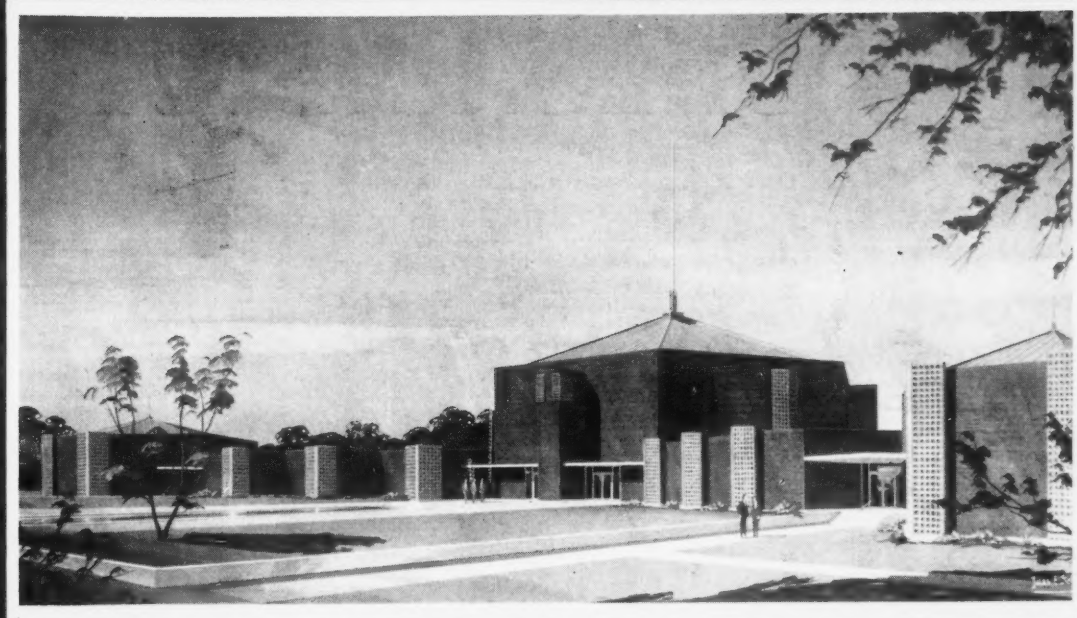

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OVER AN 8-YEAR SPAN . . . TO

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An outstanding and frequently reported characteristic of CHLOROMYCETIN[1-8] "...is the fact that the very great majority of the so-called resistant staphylococci are susceptible to its action."[1] In describing their study, Rebhan and Edwards[2] state that "...only a small percentage of strains have shown resistance..." to CHLOROMYCETIN, despite steadily increasing use of the drug over the years.

Fisher[3] observes: "The over-all average incidence of resistance, for the 31,779 strains [of staphylococci] through nine years was about 9%." Finland[4] reports that, while the proportion of strains resistant to several newer antibiotics has risen to between 10 and 30 per cent, such resistance to CHLOROMYCETIN "...has been rare even where this agent has been used extensively." Numerous other investigators concur in these findings.[5-8]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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Editorial

Talking Sense

"If the technique of reducing ideas to a simple form, and placing them in logical order, were carried out extensively, only a few of our clinical ideas would come through unscathed.

> " 'Our path is cumbered with guesses, presumptions and conjectures. The untimely and sterile fruitage of minds which cannot bear to wait for the facts, and are ready to forget that the use of hypotheses lies, not in the display of ingenuity, but in the labour of verification.'—Clifford Allbutt.

Stress

"Consider the ubiquitous stress factor, now accepted as the origin of many modern diseases—peptic ulcer, asthma, and ulcerative colitis. Here is a particularly well-written passage on this subject, from the pen of a distinguished physician:

> " 'Peptic ulcer—one of the pestilent camp followers of civilization—one of the penalties we pay for our boasted progress, seems to be more than keeping pace with our advancement, and to be attaching itself especially to certain forms and phases of civilization. There is reason to believe that it is, if not of modern origin, at least of modern growth, and that modern habits and modern modes of life have something to do with its propagation. This is essentially a feverish and fidgetty age, in which an unappeasable restlessness pervades all ranks and classes. The struggle for existence has become a melee, and the recommendation to "commune with your own heart in your chamber, and be still" is looked upon as an obsolete adage. The result of all this ceaseless agitation and ambitious striving is that the gastric mucosa often gives way under the strain imposed on it. By a hideous kind of poetical justice, peptic ulcer has become a distorted reflection of the follies of the age. It is the miserable otium cum dignitate of the man of business.'

"May I now admit, with apologies, which are not very sincere, that I have been guilty of a trick. I deliberately altered two words in that passage. Wherever it said 'G.P.I.', I substituted the words 'peptic ulcer', and where it mentioned 'the nervous system', I wrote in the words 'gastric mucosa'. Apart from that, those are the actual words spoken by Dr. James Crichton-Browne in 1871, about the cause of general paralysis of the insane, at the seventh meeting of the Medico-psychological Association.[1] It makes one think. We hold such very different views about the cause of G.P.I. today. It can still provide otium for business men, but cum much less dignitate.

"In the case of psychosomatic disease, are we not reasoning as follows: the pace of modern life is going up; the incidence of peptic ulcer is also going up; therefore the pace of modern life is the cause of peptic ulcer? What prices 'guesses, presumptions, and conjectures'?

"Why indeed is it so often presumed that the speed of civilisation always involves stress and strain? Crossing the Pacific in a Comet is less strain than crossing it in a coracle, and cave-men were probably as much troubled by shortages of suitable flints as modern man is troubled by his income-tax.

"The danger of psychosomatic explanations for unexplained diseases is that they are so easy to find and provide such a comforting illusion that something has been explained, when it has not. That is why I regard Crichton-Browne's remarks on G.P.I. as a valuable warning.

Comforting Illusions

"It is important to recognise that things are much easier to believe if they are comforting, and that many clinical notions are accepted because they are comforting rather

From the third Lettsomian Lecture by Richard Asher, M.D., F. R. C. P., delivered before the Medical Society of London on Feb. 16, 1959. Abstracted by permission from *The Lancet*, 2: 417 (Sept. 26) 1959. See the JOSMA, July and August for abstracts of the first and second lectures.

1. F. ment. Sci. 1871 - 72, 17, 147.

than because there is any evidence to support them. Just as we swallow food because we like it, and not because of its nutritional content, so do we swallow ideas because we like them and not because of their rational content.

"Crawshay-Williams'[2] penetrating philosophical study of irrational thought called The Comforts of Unreason is a work I have found most enlightening, and its list of what he calls 'comfortable concepts' is highly informative. One comfortable concept, which most of us accept without being aware of it, was heartlessly exposed by Dr. Ronald Bodley Scott in a previous Lettsomian lecture. 'The science of therapeutics,' he said, 'is founded on the touchingly naive assumption that there is an answer to every question it poses.'[3] How uncomfortably true that is, and how few people have the courage to say it! We always say 'What is the treatment of this disease?' rather than 'Is there a treatment for this disease?' Even the expression 'effective treatment' is a quaint one. We do not talk of 'mobile motor-cars': we assume that they move, because that is their purpose and function. Logically we should not give treatment unless it is effective.

"From this I obtain a concept which I believe to be true but which I find too depressing to accept: 'It is better to believe in therapeutic nonsense than openly to admit therapeutic bankruptcy.' (Better, in the sense that a little credulity makes us better doctors though worse research-workers.) I find this very uncomfortable. If you admit to yourself that the treatment you are giving is frankly inactive, you will inspire little confidence in your patients (unless you happen to be a remarkably gifted actor), and the results of your treatment will be negligible. But if you believe fervently in your treatment, even though controlled tests show that it is useless, then your results are much better, your patients are much better, and your income is much better too. I believe this accounts for the remarkable success of some of the less gifted but more credulous members of our profession, and also for the violent dislike of statistics and controlled tests which fashionable and successful doctors commonly display. It is an almost insoluble problem, and the majority of worthwhile doctors are driven to a compromise in which they muster enough genuine belief in their treatment to keep their patients happy and maintain their own self-respect, while preserving enough doubt to admit their inadequacy during transient bouts of uncomfortable honesty.

" . . . . The laity are equally prone to adopt comfortable concepts. One of the most irrational and comforting delusions held by the layman is the notion that his body is really a kind of motor-car. 'I feel much better now you've given me a thorough overhaul' is a remark I have heard on many occasions. Doctors are often guilty of nourishing this delusion when they make remarks such as 'You'd better come in for a complete check-up.' Behind all this lies the delusion that the physician is likely to remedy defects as he finds them—applying a little oil here, fitting a replacement there, and possibly clearing out a blocked pipe. Business men and high-up executives like to have 'complete check-ups' at regular intervals, when they can go into a clinic for a lot of expensive investigations. This emphasises their importance ('we always have the Rolls decarbonised every 5000 miles to keep it in tip-top condition, but we don't bother about the utility van'), and also it gives them a feeling of security, as they come out of the clinic rejuvenated by a comforting illusion of physical decarbonisation. But the analogy with motor-car engines is false, and the only point where it applies is that when the trouble is very serious the patient is likely to be returned to his Maker.

" . . . . I do not deny that most cases of hypochromic microcytic anaemia are caused by lack of iron, but I do criticise the term 'iron-deficiency anaemia' to describe the appearance of the film. First, because this is unjustifiable in logic; secondly because it involves naming by supposed cause and not by observed fact; and thirdly because it contains an important assumption. It assumes that this anaemia is an illness—that something is wrong, and that it needs putting right. This assumption may be correct, but we ought to be aware of it.

2. Crawshay-Williams, R. London, 1947.
3. Scott, R. B. Trans. Med. Soc. Lond. 1957, 73, 132.

" . . . . You cannot say what things are abnormal till you have agreed on what is normal. You cannot describe disease without describing ease first.

"This cardinal principle is often forgotten —as it applies to the word 'constipation', for instance.

"Here we have all the elements of confusion. First are we naming the state of the bowels or the symptoms we attribute to that state? Secondly, are we naming an abnormality, or making a neutral statement about a function? If a man's bowels are usually open on alternate days, and he comes into hospital 36 hours after they were last open do we correctly write in the notes 'constipated for 36 hours', or does this not differ in meaning from the statement 'bowels last open 36 hours ago'? It is too easy to assume that the frequency or regularity of normal bowel action has been decreed by some natural law. We behave as if the human colon had been supplied with a maker's tag reading 'This tube should be cleared out once every 24 hours'. We never lay down a statutory number of times that the bladder should be emptied each day. Why not? Why do we do so with the bowels? What is constipation? I looked the word up in my dictionary and it said 'costiveness'. Then I looked up the word 'costive' and it said 'contipated'. So I cannot answer the question, or the many others I raised in connection with it.

"I can only reiterate Allbutt's words: 'Our path is cumbered with guesses, presumptions and conjectures.'

* * *

"I turn with relief to the more solid ground of common sense—the capacity to see the obvious even amid confusion, and to do the obviously right thing instead of working to rule.

"When I was a boy, I was skating on the lake of Earls Colne Priory, when a lady fell and broke her leg. Many of the bystanders were acquainted with the rules of first aid and knew just what to do—'keep her warm' and 'Do not move her till the doctor comes.' Maids hurried from the house with hot drinks, hot water-bottles, and luxurious furs: Nutria lay upon beaver, and musquash was piled on mink. I skated gently around the stricken lady who groaned beneath her expensive load. The doctor seemed to be hours coming; so more hot bottles were added. Suddenly a matter of elementary physics began to be apparent: warmth melts ice. There were ominous cracking sounds; first-aid principles were forgotten, common sense was remembered—and we got her off the ice just in time. A few more seconds and that lady, together with a very valuable collection of furs, would have been lost."

New Film Outlines Doctors' Role in OASI Disability Program

A new film presentation on the Old-Age and Survivors Insurance disability program is now available for showing to physicians and allied professional personnel.

Produced and released by the Bureau of Old-Age and Survivors Insurance with the cooperation of the American Medical Association, the film is entitled "The Disability Decision."

First shown at the American Medical Association's Annual Meeting in June, the film is a highly professional product using case histories to illustrate the problem of communication involved in obtaining sufficient information about each specific disability case and also in giving both the physician and his patient an understanding of just what the law means by the term "disability." Emphasis is placed on showing physicians why a full medical picture of the patient's condition, including history, physical findings, laboratory data, diagnosis and description of residual function is required to determine whether or not the patient meets the definition of disability under the law.

Prints of the 16mm black and white 30-minute dramatic presentation are now available (return postage only) from the American Medical Association Film Library, and social security district offices.

Scientific Articles

Infarcted Cysts of the Fallopian Tube

E. EVANS CHAMBERS, M.D.
HENRY T. RUSSELL, M.D.
LILLIAN HARRIS ROBINSON, M.D.

E. Evans Chambers, M.D., graduated from the University of Oklahoma School of Medicine in 1940. His practice is limited to his specialty, surgery.

Henry T. Russell, M.D., a graduate of Washington University School of Medicine, has been certified by the American Board of Pathology.

In addition to his private practice in Oklahoma City, Doctor Russell is visiting lecturer at the University of Oklahoma School of Medicine.

Doctor Russell is a member of the American Society of Clinical Pathology, the College of American Pathologists and the International Academy of Pathology.

Lillian Harris Robinson, M.D., graduated from Tulane University School of Medicine in 1942. She is a member of the American Academy of General Practice and Alpha Omega Alpha. In addition, Doctor Robinson is a member of the Oklahoma State Board of Medical Examiners.

DURING a six month period, two cases of infarcted cysts of the fallopian tube were seen by the authors. This entity is apparently extremely rare. Survey of the literature reveals 26 recorded cases of embryologic cysts of the uterine tube (teratomas). However, no reports were found of benign cysts of the tube which became infarcted, resulting in the development of an acute surgical abdomen, except for a few instances in which torsion of the cystic tube had occurred. Cysts of the tube are mentioned in gynecologic texts along with papillomas, lymphangiomas, lipomas, chondrofibromas, enchondromas, osteomas, teratomas, and hemangiomas as pathologic curiosities. The rare malignant neoplasms of the tube have been reported more frequently than the benign tumors. These include primary carcinomas, chorionepitheliomas and the relatively rare sarcomas.

Case 1. A 17 year old white female was seen on July 31, 1958. Early that morning she had developed a pain low in her right side which gradually became worse. She felt nauseated but did not vomit. She felt better when lying on her side with her knees and hips flexed. System review was essentially negative. She had previously been well except for the childhood diseases. Her menses had been regular since age 13 and aside from occasional heavy flow they were normal. Her last period had begun two weeks previously.

Physical examination revealed a well developed, attractive youngster, 63 inches tall who weighed 126 pounds. Her oral temperature was 99.2F., pulse 88 per minute,

Figure 1. Infarcted tube containing cyst at operation (Case 2).

Figure 2. Wall of "normal" hydatid cyst to show epithelial lining and connective tissue wall. Photomicrograph. 35 X.

blood pressure 110/70 mm. Hg. No abnormalities were found except for tenderness in the lower right abdomen and in the right adenexal region. Her leucocyte count was 8,600 per cubic millimeter with 69% neutrophiles, three of which were stab forms, 24% lymphocytes, 4% monocytes and 3% eosinophiles. Urine analysis revealed no abnormalities.

A diagnosis of acute appendicitis versus ruptured graffian follicle with bleeding was made and a laparotomy was performed. Bloody serous fluid was present in the peritoneal cavity. A moderately inflammed appendix was removed and the stump inverted. A gangrenous cyst like structure about 3 cm. in diameter was seen arising from the fimbria of the right tube. This structure was ligated close to the tube and removed. Postoperatively she had a very smooth course.

Case 2. A 34 year old woman was seen on February 4, 1959. Three days previously she developed pain in her lower abdomen slightly to the left of the midline. At this time she was just finishing a menstrual period. The pain gradually became worse and seemed to shift to the right lower quadrant of the abdomen. She had some nausea but no vomiting and her temperature was elevated one degree. On the morning of admission to hospital, her pain had become so much worse that she was unable to walk without bending over. System review was essentially negative. In the past, she had noticed mid-period pain in the region of one of her ovaries on several occasions and had been thought to have ovulation bleeding. Aside from the childhood diseases she had had no previous illnesses. Her menses had been regular and normal since age 14. She had had two normal pregnancies.

Physical examination revealed a well developed overweight white female, 67 inches tall, weighing 210 pounds. Her oral temperature was 99.6F., pulse 90 per minute,

Figure 3. Case #1 showing hemorrhagic infarcted wall of cyst. Photomicrograph. 35 X.

Figure 4. Case #2 showing infarcted wall of cyst. Photomicrograph. 35 X.

blood pressure 150/80 mm. Hg. Abnormal physical findings were limited to the abdomen and pelvis. There was rather marked tenderness and some rigidity in the lower right quadrant of the abdomen. The lower abdomen was also tender and slightly rigid. No masses could be palpated in the abdomen. On pelvic examination the uterus was found to be very tender when moved and the adenexal regions were exquisitely tender. No definite adenexal masses could be palpated.

A diagnosis of ruptured graffian follicle with bleeding was made and she was operated. A small amout of blood was present free in the peritoneal cavity. The left fallopian tube was found to be twisted at the junction of the proximal and middle thirds. A large cyst like structure was present in the distal third of the tube. It was gangrenous and grossly resembled a tubal pregnancy. Because of the torsion of the tube, the distal third containing the cyst lay just to the right of the midline. The left tube and ovary and the appendix were removed. Her convalescence was smooth and she left the hospital on the eleventh postoperative day.

Pathology. Hydatid cysts of Morgagni are examples of a group of cysts arising from Gartner's duct, which is a residual of the Wolffian body. The entire group is classified as paraovarian cysts. When these cysts arise from near the blind end of the tube they are called hydatids (Greek hydatis, a drop of water) of Morgagni or cysts of Morgagni.

Structurally these cysts are quite simple. They are usually unilocular. They have a thin wall composed of firm, fibrous connective tissue and varying amounts of smooth muscle. The internal surface is lined by columnar or cuboidal epithelium which is usually flattened in the larger cysts. The lumen is filled with thin clear fluid. These cysts rarely exceed 2-3 cm. in size, but they may occasionally be larger.

Novac states that such cysts are "of no special clinical significance except in the very rare case where the long thin pedicle may bring about intestinal angulation or obstruction." Faulkner and Douglas concur in this opinion.

In the first case, the gross specimen measured 4 x 3 x 1.5 cm. and was slightly club-shaped. The wall was variable in thickness and ranged from 0.5 cm. in thickness to 0.1 cm. There was extensive hemorrhage in all parts of the wall and within the lumen. The internal surface was fairly smooth. Microscopically, the cyst was lined by one to two layers of flattened, but uniform cuboidal cells. The smooth muscle and connective tissue of the wall were widely separated by extensive hemorrhage, and the blood vessels were dilated and engorged. The hemorrhage showed no degenerative changes and the wall structures showed no necrosis. This was considered evidence that the infarct was acute.

In the second case there is less certainty as to the exact nature of the cyst that was infarcted because of the severe degree of infarction. The specimen included a fallopian tube and the distal two-thirds of the tube was also infarcted. Grossly the cystic structure measured 6 cm. in greatest diameter. It was attached to the external surface of the tube but was distinctly external to the tube wall. The wall of the cyst was variable in thickness and ranged from 0.4 to 0.8 cm. The wall was infarcted and hemorrhagic. The internal lining was smooth and the lumen was filled with thin bloody fluid. Microscopically the wall was extremely hemorrhagic and moderately necrotic. The blood vessels were dilated and engorged. No definite epithelial lining could be demonstrated. It can be seen from this description that microscopically this structure cannot be identified definitely as a cyst of Morgagni. However, grossly it was quite typical in location and was definitely not a part of the fallopian tube wall or a part of the ovary.

Comment. The symptoms of infarcted cyst of the fallopian tube are quite similar to those of appendicitis, torsion of an ovarian cyst, or bleeding ovary. Torsion of the tube occasionally produces infarction and results in an acute surgical abdomen. Torsion is more likely to occur in tubes containing a cyst or other anatomical abnormality. In the second case, torsion of the tube was present. However, in the first case, no torsion had occurred and the symptomatology was thought to be due to the gangrenous cyst of Morgagni. The incipient appendicitis was thought to be secondary to the very acute process in the cyst. It is quite possible that this condition may be encountered more frequently than survey of the literature would indicate.

Summary. Two cases of infarcted cyst of the fallopian tube are reported. One was definitely a hydatid cyst of Morgagni. The other was so necrotic that positive identification was impossible, although its location and structure indicated a similar origin. Torsion of the tube had occurred in one patient. Both patients presented symptoms of an acute surgical abdomen.

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This article has to do with the treatment of th common foot problems which unfortunately hav been badly neglected in most medical schools.

The diagnosis and treatment of fallen and long tudinal and transverse arches, callouses, corn bunions, hammer toes and positional foot prob lems in children are presented.

Common Foot Problems and Their Treatment*

CARLO SCUDERI, M.D.

A 1928 graduate of the Illinois College of Medicine, Carlo Scuderi, M.D., has been certified by the American Board of Orthopedic Surgeons. He is Associate Professor of Orthopedic Surgery at the University of Illinois.

Doctor Scuderi is a member of the American Orthopedic Association, the American Academy of Orthopedic Surgeons, the Clinical Orthopedic Society and the American Association of Surgery of Trauma.

He is past-president of the Chicago Orthopedic Society.

Introduction

THE TREATMENT of common foot problems has been seriously neglected by all medical schools throughout the country. Unfortunately, more and more emphasis is being placed on major surgical procedures than on minor procedures such as painful feet and yet there are as many people having trouble with their feet as there are those that are having trouble with their eyes. One does not have to look very far to notice the number of people in our modern civilization who are wearing glasses.

The lack of interest in the treatment of foot problems probably originates from the inadequate training of the medical student so that he has no interest or very little understanding of what constitutes a poor problem and what is the treatment of this problem.

Physiology of Walking

Although all of us walk a good part of each day of our life, the mechanics of walking are not commonly understood any more than the average physician understands the true mechanism of respiration, in spite of the fact that under ordinary circumstances breathing is done ten to twenty times every minute of his life.

When an individual walks, the first part of the foot to strike the ground is the soft tissue on the plantar surface of the os calcis (Figure 1-A). As the weight comes forward the weight is then transferred to the metatarsal area of the forefoot (Figure 1-B).

At this stage of the walking, the foot is in a minimal amount of supination. As the weight is transmitted to the front portion of the foot, it is then rapidly transmitted across the transverse arch to the head of the first metatarsal (Figure 2).

When the entire metatarsal area is in contact with the ground the weight distribution in this area is in the relationship as shown in Figure 3. The first metatarsal head carries two-sixths of the total body weight

*Presented before the Oklahoma Academy of General Practice, Oklahoma City, February 15 and 16, 1960.

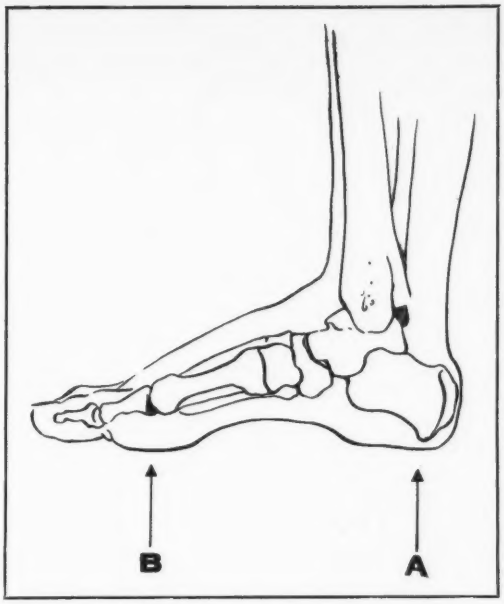

Figure 1. Schematic lateral view of the foot.

A. Soft tissues over the os calcis that in walking first come in contact with the ground.
B. Metatarsal area which comes in contact with the ground when the weight is shifted to the forefoot.

while each of the other four metatarsal heads, carry one-sixth of the total body weight. This is true under normal weight distribution when there are no displacements of the metatarsal heads.

As the weight comes forward the propulsion power in walking is exerted by the large toe. It is the propulsion power that gives us the spring in walking. This is produced by the forced plantar flexion of the large toe.

It is a lack of understanding of this propulsion power of the large toe that leads to many types of bunion operations that are harmful. Any type of operation of the large toe area that interferes with the working mechanism of the large toe contributes a surgical disability to this individual. For this reason, resections of the head of the first metatarsal to shorten it, such as done in the Mayo operation or the removal of the proximal half of the proximal phalanx of the large toe such as is performed in the Keller operation produce impairment in propulsion power and therefore a loss of the spring of walking. There is no question

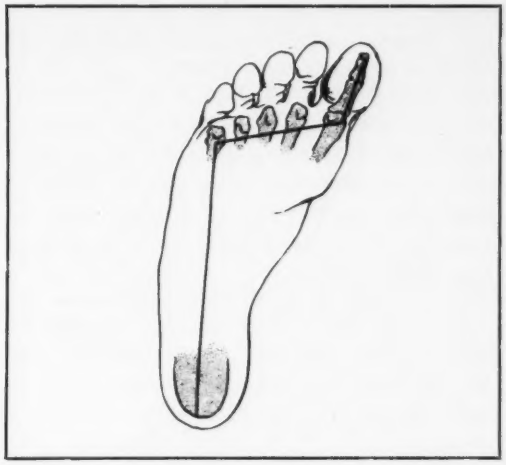

Figure 2. Plantar Surface of foot showing the most important points of ground contact in walking. After the heel strikes the ground and the weight is shifted forward, the weight is then brought to bear on the head of the fifth metatarsal. From there the weight is shifted to the head of the first metatarsal. The push off power of spring in the step is produced by the plantar flexion of the large toe.

that under certain circumstances the Keller operation is definitely indicated, and that is when a hallux rigidus exists.

A great deal of research work has been done on the amount of weight that is borne on the metatarsal head under normal circumstances. This is subject to a great deal of controversy, but to the best of the author's knowledge, as described previously, the distribution of weight is in the ratio of 2-1-1-1-1, the greatest portion of the weight being on the first metatarsal head. Very frequently a falling of the transverse arch produces pain and discomfort to the patient

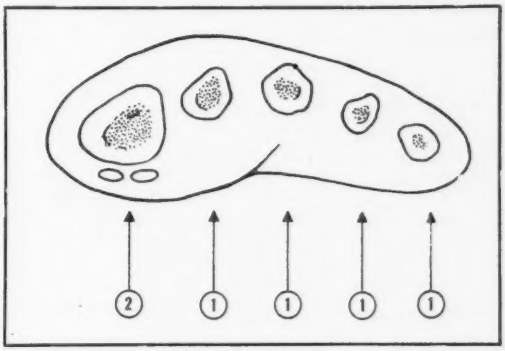

Figure 3. The normal weight distribution to the metatarsal area is shown on this drawing. One third of the total weight is borne by the first metatarsal head.

because of abnormal weight bearing and in some instances there is actual pinching of the intra digital nerve. There is a secondary involvement of the skin with callous formation as a result of abnormal weight bearing. The simple inspection of the plantar surface of the foot shows whether or not there is abnormal weight bearing present, and nature shows us exactly where the abnormal weight bearing is. When the person has a fallen transverse arch, the distribution of weight may shift considerably, for example the weight bearing may be in the relationship of 1-2-2-1-0 with the second and third metatarsal heads each carrying two-sixths of the total body weight, therefore two-thirds of the body weight is being carried on the second and third metatarsal heads (Figure 4). A callous rapidly forms in this area.

Women's Footwear

It is common knowledge that more women have trouble with their feet than men. Not very long ago a colleague of mine asked how many bunion operations I had done on male patients in the last five years. I was somewhat embarrassed when I realized that I could not recall a male patient that had a bunion operation but I could recall dozens and dozens of women patients that I have performed bunion operations upon, in the last five years. There is a reason for this.

The present style of women's footwear has a very high heel somewhere between three

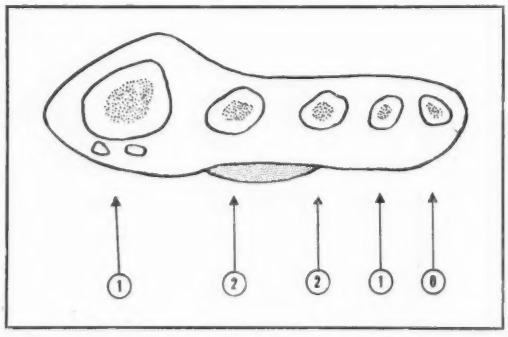

Figure 4. Abnormal weight bearing produces the greatest portion of the weight to be carried on the heads of the second and third metatarsals. A resulting callous occurs in this area, illustrated by the shaded part in the drawing.

Figure 5. The present style in women's shoes throws the majority of the total body weight on the metatarsal heads. This is an area which was never intended by nature to carry all this weight. This causes a break down of the metatarsal arch.

and four inches in heights with very pronounced pointed toes. When a woman gets on high heels most of her body weight is transmitted to the metatarsal head (Figure 5), instead of being primarily borne on the os calcis area. In addition to this body weight being in an abnormal location of the foot, the toes and the front portion of the foot are jammed into a wedge shaped pointed toe of the shoe. The large toe because of its size has seniority, and therefore occupies the medial half of the toe of the shoe. The other four toes have to be squeezed and overlap one another as best they can, and invariably the fifth toe develops callouses, becomes distorted in shape, and overlaps the fourth toe (Figure 6). The second, third and fourth toes overlap and squeeze one another into the most grotesgue disfigurations. It must be accepted by the treating physician that he is not going to change women's styles and therefore he must go along and do the best he can with the present styling of women's shoes.

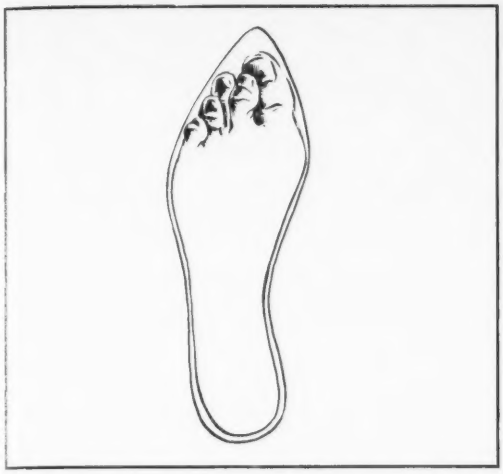

Figure 6. The pointed toes of modern women's footwear, pinches the toe together, producing grotesque deformities and many abnormal pressure points.

Paraphenalia for Foot Examination

If one is going to treat certain foot problems, he must by necessity have certain equipment. Since most of the foot problems start with improper shoes one must have a measuring device to determine the length and width of a proper fitting shoe. The one device which has been most suitable to the author is called the Brannock Device, which is used by many shoe salesmen. This gives the heel to ball and heel to toe measurement, and also the width of the foot. The most important measurement is the heel to ball measurement. This is the essential part of the weight bearing portion of the foot, and in individuals who have long or short toes the overall measurement may vary considerably, from the heel to ball measurement. When there is a discrepancy between the two, the heel to ball measurement is the one of critical importance and this is the size shoe that the patient should wear. Invariably, especially in women, the shoes are much narrower than the measurement on the Brannock Device. Here it requires the judgment and skill of a Socrates to inform a woman that she should wear a wider shoe and fortunate is the doctor who has the "know-how" to convince a woman of this fact.

Facilities to get weight bearing foot imprints must be available in order to determine points of excessive pressure on the plantar surface, and also the contour of the longitudinal arches.

The author has tried many methods. The one which he is using at the present time is the one made by Scholl's Manufacturing Company. It is a sheet of paper upon which an inking pad comes in contact. Over this there is a rubber sheet upon which the patient puts his foot. The patient stands on this rubber covered pad, and then this in turn transmits an imprint on the underlying paper. It shows the longitudinal arches and from the intensity of the inking on the pad one can determine where the points of maximum pressure are. This pedigraph is shown in Figure 7.

If one does not desire to use this pad, other methods are available. The solution made out of the following prescription, Tincture of Ferric Chloride, 50%; Alcohol 45%; Glycerin 5%; can be applied on the plantar surface of the foot with a one inch brush. The patient then steps on plain white paper. This leaves an orange type imprint on the white paper which is permanent. It has one disadvantage, however, that Tincture of Ferric Chloride does not come off with soap and water and has to be removed by alcohol. Another method which the author has used for some time is the use of orange litmus type paper which is made by the Kleistone Rubber Company of Warren, Rhode Island. This requires the application of a saturate solution of Sodium Bicarbon-

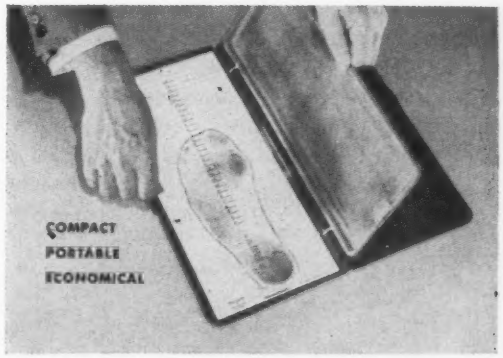

Figure 7. Scholl's pedigraph. This ingenious device uses the principle of an inking pad without soiling the foot. Abnormal pressure areas appear as darker spots. This is an excellent method of taking foot imprints.

ate to the plantar surface of the foot with a one inch brush. The patient then steps on the litmus paper and this leaves a permanent imprint. The use of a teaspoon of baking soda in a four ounce bottle of plain water is all that is necessary and this should be shaken each time before use to get the solution in a saturated state. It leaves no staining on the plantar surface of the foot that has to be removed.

Many foot problems require instructions on how to do foot exercises in order to strengthen the intrinsic muscles of the foot. It is very time consuming for the attending doctor to instruct the patient how to do the foot exercises, and very frequently half of them are forgotten by the patient before he gets home and some of the others are not done properly. A number of years ago the Walkover Shoe People put out a very fine booklet with the instructions on foot exercises and they have been kind enough to send me a supply over the years, for a nominal charge. These are given to the patient when indicated. Further discussion will be given later as to the use and indications for foot exercises.

Children's Foot Problems

Practically all foot deformities in infants can be corrected if treated early. Club feet and metatarsus primus varus should be treated as soon as diagnosed, within a few days after birth. All club feet are best treated on diagnosis. Experience shows that the earlier the treatment is instituted the more rapidly will the recovery take place and the end results are far better. Neglected club feet sometimes lead to complications and future operations which are usually avoidable. The exact treatment of these conditions is beyond the scope of this article.

A common problem in children is the toeing in of one or both extremities. This is invariably due to muscle imbalance. The treatment is quite simple. The parents are instructed to externally rotate the feet twenty-five times after each nap and the first thing in the morning when the child awakens. In cases that are persistent the use of Dennis Browne Splints (Figure 8) with a cross bar and the attached shoes is very useful. The affected foot or feet are treated by gradual external rotation of the ratchet on the brace so that the foot is held in progressive external rotation. Usually in a matter of several months this deformity can be easily corrected with no residual bad results.

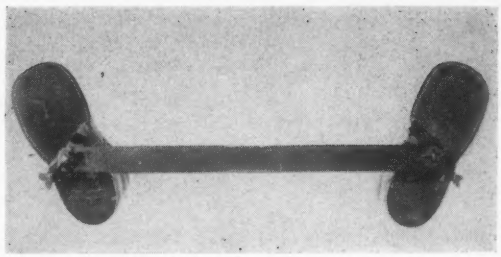

Figure 8. Dennis Browne splints with everson of the feet, used for children who toe in. This splint with the attached shoes is used during the child's sleeping periods.

When the child is up walking it is important that he wear a rigid shank shoe that has a three-sixteenths inch wedge on the outer border of the sole so that in walking the foot will be constantly turned outward by the wedge and the superimposed body weight.

Toeing out presents another problem. It is important that all children who have a toeing out deformity, especially infants, have an x-ray taken of the hips in both the anteroposterior and frog position to rule out the possibility of a dislocation or a subluxation of the hip. If this exists it must be treated immediately otherwise further difficulties arise with the formation of the acetabulum.

Everyone is acquainted with the fact that the physical findings of a congenital dislocation of a hip are easily recognized if one simply remembers that the condition can exist. The following list presents the pertinent physical findings:

1. The leg is shorter and in external rotation on the affected side.
2. The groin crease and the gluteal crease on the affected side are higher than on the unaffected side.
3. If the knees are flexed and the feet are

placed flat on the examining table the knee on the affected side is lower than the unaffected side because of the posterior displacement of the head of the femur.

4. External rotation is restricted on the affected side compared to the unaffected side.

If no congenital hip dislocation or dysplasia of the hip exists, then the condition is due to muscle imbalance. The parents are instructed to turn the feet in twenty-five times, three to four times a day. In cases that are moderate to severe in nature, they should be treated by the use of Dennis Browne Splint but with the feet turned in inversion (Figure 9).

When these children are up walking they should be fitted with high shoes, with a rigid shank and although it may seem paradoxical the three-sixteenths inch wedge should be on the inner border of the soles so that in walking there is a constant dynamic force that turns the foot in, into the corrected position.

Another complication that one sees in children are the adduction deformities of the large toe or the hallux primus varus. In cases that are seen in infancy it is best that they be manipulated in a plaster cast extending from the tip of the toes to the groin with the knee at right angle, and the ankle at right angle, with the wide adduction of the forefoot. When the correction has been attained or if the child has a mild adduction of the large toe, then the use of pigeon toe shoes are advisable. This has an abduction of the forefoot and also has a wedge of three-sixteenths of an inch on the outer border of the sole.

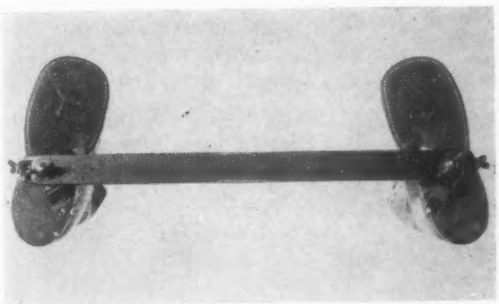

Figure 9. Dennis Browne splints with inversion of the feet, used for children who toe out. This splint with attached shoes is used during the child's sleeping periods.

Most children's problems can be solved readily if recognized and treated early. It is a common mistake for the parents and the doctor to say that the child will outgrow it.

A common, unrecognized fact is that all children have flat feet until they are old enough to be up and about. Until then they have not had an opportunity of wearing down the fat pad that nature has placed on the plantar surface. Invariably a mother will bring a child in and state that the child's feet are flat and that her husband has flat feet and she desires to have something done about it. We know that children with this problem will get well spontaneously, by the use of a small longitudinal arch of both feet. This will quiet the mother, will help in the correction of the problem and in the final analysis will cover the doctor, with perhaps, undeserved glory.

Corns and Callouses

A corn or callous is the result of abnormal weight bearing. The callous itself is a thickening of the epidermis and it is the author's belief that a corn is simply the further progression of this callous formation with a thickened skin and epidermis that runs deeper into the tissues and has what appears to be a core.

In the treatment of callouses and corns the usual problem is tight shoes, or abnormal weight bearing, such as in the metatarsal area. This must be corrected first otherwise the condition will recur regardless of what other form of treatment is used.

It has been found that the local application of 10% Salicylic Acid in flexible Collodian applied every night to the callous is very beneficial in its removal. The following evening the foot should be soaked in real hot water for about fifteen minutes. Some of the callous will come off spontaneously after each soaking.

The use of a cutical cutter, such as used in trimming the finger cuticle or a very sharp thin knife or a razor blade is advantageous in trimming down the callous, if it is thick.

Under this regime callouses and corns can be taken care of.

Fallen Arches

Everyone recognizes the fact that there are two arches in the foot a longitudinal and transverse arch.

It is axiomatic to state, that a painless flat foot should be left alone. It is only when the flat foot gives rise to symptoms that it should be treated.

The usual etiological causes for flat feet are the following:

1. Obesity.
2. Poor walking position with the foot in external rotation.
3. Occupations in which the patient must be on his feet for long periods of time, such as a postman, policeman or waiter.
4. Cement pavement upon which people have to stand for long periods of time during their occupations, such as sales people and people who work at machines.

Sometimes there is an element of simple weakness of the longitudinal structures, and the calcano valgus position of the heel is a very common etiological cause for flat feet, especially in young people.

The treatment of the longitudinal foot problem depends on the degree of the pathology.

If the cause is overweight, this might be corrected. If the cause is occupation it is not always easy to change the occupation and one will have to do things to help the feet counteract this occupational stress.

If the heel is in a calcano valgus position, the use of a Thomas heel which is about half an inch longer on the medial border than the lateral border is advantageous. The use of a wedge on the medial border of the heel about one-eighth or three-sixteenths of an inch will get the calcano valgus into a more normal position.

The use of longitudinal pads is important. They should be placed so as to relieve the patient of his discomfort and they should be built up only to the extent that it is necessary to relieve the symptoms. The height of the pad is not as important as the symptomatology. Commercial pads are available that are made out of sponge rubber and leather and these are the ones that are recommended by the author. They can be purchased through many supply houses throughout the country but the ones that the author has used for years are made by the Kleistone Rubber Company at Warren, Rhode Island.

Construction of the shoe is important. Individuals who are overweight and who break down the shoes readily should have special shoes with a rigid shank, giving them rigidity. A long counter, which is a fiber type of reenforcement between the leather layers on the inner or medial border of the shoe, gives additional support and the patient cannot break down the shoe readily. This happens all too frequently in overweight people, especially those of advanced ages.

Exercises are important. This is especially true in young people. The booklet which has been recommended, published by the Walker Shoe Company, serves this purpose very well. The exercises should be done every night before going to bed, for five to ten minutes depending on the degree of the pathology and the cooperation of the patient.

The three principle exercises which are recommended are:

1. The coming up on the toes on the count of one, the coming down on the lateral aspect of the foot and curling the toes in on the count of two and the placing of the foot in the normal position at the count of three. This is done rhythmically twenty-five to thirty times each evening.
2. Walking on the lateral aspect of both soles with the toes curled under. This places the heel in a marked calcano valgus position. The patient should walk

the length of the bedroom, fifteen times each evening.

3. Improvement of the function of the short flexors and the plantar structures of the foot by exercising the toes in the flexion position over the end of a large book. The exercise of trying to pick up a handkerchief or marbles or a pencil with the bare feet. This is achieved readily by children but is quite difficult for older people.

The treatment of the fallen transverse arch is not too difficult, when one realizes as stated above, that the distribution of the weight over the metatarsal heads is very important. Nature has been very kind in producing a callous where there is too much weight and if the examining doctor will simply examine the bottom of the foot he can see where the abnormal weight is being borne. The callous must be treated locally by the use of 10% Salicylic Acid in flexible Collodian and by trimming the callouses each evening as stated previously. A proper fitting pad should then be inserted into the shoe under the metatarsal region. This cannot be done by guess work. It must be done accurately. The measurement is made from the back of the callous to the back of the heel and then this exact measurement is placed into the shoe. The metatarsal pad is then inserted accurately in this area, usually starting with the low metatarsal pad. The pad is increased in size until the patient is free of symptoms. Usually the pad will feel strange for a matter of a week or ten days. The patient should be informed of this. If his symptoms are not relieved then a larger pad is placed in the shoe until he is comfortable. Once the patient is comfortable no further change in the pad should be made.

The author thinks that one is better off with a pad that is glued into the shoe and stays in a fixed position rather than having a pad that can be moved from one shoe to the other, and never in quite the same position.

When a metatarsal pad is used it is necessary that the patient have a closed heel and closed toe shoe, otherwise it probably will be unsuccessful. It is very difficult to put a metatarsal pad in the shoe and have it work successfully if the patient is on a high heel with an open toe. For this reason when metatarsal pads are inserted it is best that the patient be on a Cuban heel or a nurses shoe, with a heel that is not higher than one to one and a quarter inches.

Painful Heels

Very commonly patients complain of pain and discomfort in the heel. Surprisingly few people have a calcaneal spur. This can be best diagnosed by a lateral x-ray film. If the calcaneal spur is present it is sometimes necessary to remove it surgically if conservative management has failed. The conservative management will be described shortly.

Many people have a bursitis over the os calcis that gives then this pain and it is important that the pressure be relieved from this area. Some medication should be given by mouth to reduce the inflammation in this area. Some believe that the pathologic change is similar to that found about rheumatoid joints.

The insertion of heel pads with a circular opening in the center or the use of half moon heel pads so that the pressure is sustained on the periphery rather than on the center is very worth while. The use of different size heels in several pairs of shoes is worth trying. The patient should have one pair of shoes with heels one-half inch higher than the standard height. On alternating days the shoes are changed with the regular shoes so that the weight is never quite in the same place in the heel on two consecutive days. If the patient feels better with one pair than the other then he should wear the shoe with the heel height that gives him the most relief.

The soaking of the feet each night in hot water with a level tablespoon of Epsom salts to a gallon of water seems to give relief to a lot of these people. The application of Analgesic Balm locally after the hot soaks is recommended.

Some form of salicylate seems to help these people and the one that we use is commercially prepared, Pabalate. Other forms

of salicylate therapy, I am sure are equally as good. Under this regime the majority of these people are cured of their painful heels.

In individuals that have calcaneal spurs, the removal of the spur surgically is only indicated after conservative management has failed. It is a well recognized surgical fact that if the pressure is kept off of the spur for a while that nature will lay down a very thick fibrous mass around this calcaneal spur and in many cases the patient will become symptom free.

It is symptomatology and not the x-ray findings that determine whether or not a patient should have surgical treatment.

Foot Problems That Require Surgical Correction

The surgical corrections of certain foot problems should be delegated only to a man who is trained in this particular field. Suffice it to state that such things as hammer toes, bunions, bunionettes, hallux rigidus are definite surgical entities and can be cured successfully by operation. The details of the surgical procedures will not be discussed in this paper since this is beyond the scope of this discussion. These take one far afield from the material which is available or should be used by a man who has not been trained in this particular form of orthopedic surgery. The erroneous belief that many laymen have that bunion operations are not successful or beneficial is not justified. In some instances their reaction is correct, because in the past some of the bunion operations have been harmful. They destroyed the relationship of weight bearing to the metatarsal arch and the propulsion power of the large toe as described previously.

Suffice it to say that everyone should recognize the fact that surgical correction to feet can be done very skillfully and with excellent results. Should a general practitioner be presented with such a problem, then his only decision should be one of referral. They should be sent to men who do this particular type of work. I am sure that in every community there are those who are capable of doing this type of operation very skillfully.

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Acceptable for 12 hours Credit, Category 1, by the American Academy of General Practice

The increasing number of our aging population having a C.V.A. with a resulting hemiplegia necessitates the medical profession outlining a rehabilitation program to prevent deformities, endeavoring to help the patient become independent in meeting the demands of daily living.

Hemiplegia and Rehabilitation

GEORGE G. DEAVER, M.D.

George G. Deaver, M.D., graduated from the University of Pennsylvania School of Medicine in 1917 and has been certified by the American Board of Physical Medicine and Rehabilitation.

Doctor Deaver is Professor of Clinical Rehabilitation and Physical Medicine, New York University Medical College and Director of the Department of Physical Medicine, Lenox Hill Hospital, New York.

Among the organizations in which Doctor Deaver is active, are the American Congress of Preventive Medicine, the American Academy of Preventive Medicine and the American Academy of Cerebral Palsy.

IT IS ESTIMATED there are over one million persons who have had a "stroke" and are disabled because of the result of a hemiplegia. It is listed as the third major cause of death, ranking behind heart disease and cancer. The majority of patients who have a C.V.A. do not die during the initial state but live a number of years with their residual disability. Because of the number involved, the rehabilitation of the hemiplegic patient is of great importance.

One of every 200 live births results in brain damage to a child, which is diagnosed as cerebral palsy, and one-third of the total cerebral palsy population are hemiplegic.

In general, the etiology, pathology and disabilities are similar but there is some difference in the rehabilitation program for children and adults, which will be discussed.

Etiology—The principal causes of hemiplegia are congenital, traumatic or due to disease.

Congenital hemiplegia may be the result of absence or malformation of the cranial contents or anoxia and injury at birth. These cases are diagnosed as cerebral palsy.

Traumatic hemiplegia may be caused by fracture, sheer force, bullets or the result of surgical procedures.

Disease which is the most frequent cause of hemiplegia in adults may produce the paralysis by alteration of the architecture of the blood vessels through spasm, thrombosis, emboli or hemorrhage. These changes usually result from cardiovascular disease.

Disabilities which result from a cerebral accident are limitation of motion of the

joints on the affected side and a spastic or flaccid paralysis. There may be a facial paralysis and if the paralysis occurs in the dominant arm, the patient will usually have aphasia.

Evaluation of the Disabilities. If the treatment is started early there will be no limitation of motion at the joints and the affected arm and leg can be passively moved through their normal range. If, however, the patient is not given early rehabilitation, contractures usually result, especially at the shoulder.

A flaccid hemiplegia only occurs in a small percentage of patients. The usual spastic hemiplegia presents the following signs:

The affected arm is internally rotated and adducted and the forearm, wrist and fingers are flexed. When the patient is asked to move his affected arm, he will elevate the shoulder and abduct and internally rotate the arm. When the patient's leg is fully extended voluntary dorsal flexion of the foot is impossible. When, however, the knee is flexed and the patient flexes his hip against resistance, the foot will dorsiflex and supinate. (Strumpell's phenomena).

Some individuals may have an angiospasm of the cerebral vessels and present a typical hemiplegic syndrome. There is usually a complete return of function in a few days. If a patient has a normal return of function in the upper extremity the lower extremity will usually be found to be normal.

The speech disability should be evaluated by a speech pathologist.

Treatment. The purpose of a program of rehabilitation for the hemiplegic patient is (1) to prevent deformities; (2) to treat deformities if they occur; (3) to retrain the patient in ambulation and elevation activities; (4) to teach the patient to perform the activities of daily living and working with the unaffected arm and hand; (5) to retrain the affected arm and hand to its maximum capacity, and (6) to treat the facial paralysis and speech disability if they are present. The rational of treatment is based on man's development of movement through the ages.

1. Prevention of Deformities. The spastic hemiplegic patient, when lying in bed holds the upper extremity in adduction and internal rotation with the elbow, wrist and fingers of the affected part in a flexed position. The affected lower extremity is usually flexed and adducted at the hip joint, the knee is flexed and the ankle is plantar flexed and supinated. If treatment is started within a few days following the cerebral accident there is no need for any special procedures to protect the affected limbs. If, however, due to hemorrhage in the brain or other complications, the patient must remain in bed for a period of time, then procedures must be instituted to prevent deformities.

Procedures. A posterior ankle splint is needed to prevent shortening of the heel cord. A pillow in the axilla will prevent adduction and internal rotation of the shoulder joint which is a frequent residual deformity in hemiplegia. Passive movements of the arm in abduction, external rotation and in the overhead position should be performed several times a day to prevent a "frozen shoulder."

2. Treatment of Deformities. The principal deformities which occur are a "frozen shoulder" and short heel cord.

Procedures. The use of heat and massage to the arm and shoulder are of value in preparing the part for stretching. Passive movements of the shoulder joint are necessary in increasing the range of motion. These exercises can be performed by a therapist, nurse or by the patient.

Exercise I—To prevent a "frozen shoulder joint." Position: Sitting on a chair or lying supine in bed. Instructions: The wrist of the affected arm is grasped firmly and the arm is raised (1) forward and upward; (2) then sideward and upward over the head; (3) the arm is raised sideward, and upward to shoulder level, and then rotated downward and upward.

Exercise II—To maintain full range of motion at the elbow joint. Position: As in

Exercise I. Instructions: The wrist of the affected arm is grasped firmly and the forearm is flexed and extended at the elbow joint.

Exercise III—To maintain pronation and supination. Position: In the sitting position with arms resting on the knee. Instructions: The wrist of the affected part is grasped firmly and the forearm is rotated so the palm of the hand faces upward.

Exercise IV—To maintain extension of the fingers. Position: As in Exercise III. Instructions: The fingers of the affected hand are forced into full extension.

To prevent or maintain the range of motion at the ankle joint the following procedures are suggested:

Exercise V—To maintain dorsal flexion at the ankle joint. Position: Patient is lying in supine position. Instructions: Therapist places left hand on patient's knee and with the right grasps the heel of the foot. Then with the forearm he forces the patient's foot upward and inward.

This exercise is usually all that is necessary to maintain the normal range of motion. If, however, the heel cord has contracted it may be necessary to wear a brace in bed or to surgically lengthen the tendon.

3. To Retrain the Patient in Ambulation.

The primitive pattern of flexion and extension movements at the hip and knee can usually be performed by the patient with spastic hemiplegia who is started on early ambulation. When the knee is fully extended the patient cannot voluntarily dorsal flex the foot. Only man and the monkey have an ankle, and this movement which came late in evolution can never be regained. When the knee is flexed and the patient flexes the thigh the ankle will dorsal flex and usually supinate (Strumpell's phenomena). The patient is usually afraid to place the supinated foot on the floor because of the danger of turning the ankle and falling. To prevent this foot movement he walks with the knee joint fully extended and circumducts the affected lower extremity. This is a slow awkward gait, and if used for a period of time the patient will develop a pattern of walking which will be difficult to correct. It is advisable to prescribe a double bar long leg brace with a stirrup attachment, 90 degree ankle stop and a supinator "T" strap to prevent plantar flexion and supination of the foot.

To retrain the patient's walking pattern, the following method is suggested:

Position: The patient stands with both feet together and balances himself with a cane in the unaffected hand. 1—Steps forward with unaffected extremity. 2—Flex the knee of the affected extremity while the foot is in contact with the floor. 3—Flex the hip, raise the extremity from the floor and step forward and at the same time move the cane forward. The foot will doriflex if the knee is flexed before the foot is raised from the floor.

The therapist can help the patient develop this pattern if he pushes the knee into the flexed position.

A patient with a flaccid paralysis of the lower extremity will usually need a long leg brace with ischial support to begin walking.

Though the patient cannot voluntarily flex his hips when lying in the supine position, he will be able to move the affected extremity forward when standing. The sensory contact of the floor stimulates the reflex pattern of walking.

The flaccid lower extremity should be given re-education, and in the majority of cases hip and knee movements will return and it is often possible to cut the long leg brace down to a short leg brace.

4. To Retrain the Upper Extremity.

As a return of function in the affected upper extremity cannot be expected for a long period of time, if it ever does return, it is essential to teach the patient to care for his daily needs with his unaffected arm. "A lobster can grow a claw, a man cannot, but he has what the lobster does not have, a brain to meet the needs of the situation."

A right hemiplegia in a right-handed person is a serious disability because of the

sensory and motor aphasia and the lack of skill in the left hand to perform the activities essential for daily living. The training of the left hand should be started early as the patient must become left handed if he ever hopes to care for his daily needs. Simple tasks in eating and dressing should be started. Left-hand writing must be practiced as this is an important means of communication, especially when speech is affected.

Training of the affected arm is started while the patient is developing one-handed skills with the unaffected arm. If the arm is flaccid, a reeducation program similar to that used in poliomyelitis should be started. Many of these patients have some return of function if muscle reeducation is carefully given over a long period of time. The rehabilitation of the spastic arm should start at the shoulder. The most difficult shoulder movement for the patient to regain is external rotation. Flexion and extension of the forearm is difficult for the spastic hemiplegic to perform. When asked to flex the elbow, he elevates the shoulder and abducts and internally rotates the arm. Pronation and supination of the hand are usually impossible, as these are the last movements learned by man and the last to return. Internal and external rotation of the arm are primitive movements and the patient attempts to substitute these movements for pronation and supination. The fingers and thumb are usually flexed tightly. If the fingers and thumb are forced open they can be flexed but active extension movements are usually impossible. On yawning, the fingers of the hand usually extend.

The exercises to maintain the normal motion of the affected extremity have been described.

It is necessary to test if there is a sensory disability which may be more disabling than the motor. The most serious sensory disability is the inability to recognize objects or forms by touch (asterognosis). This can be tested by having the patient close his eyes and then endeavor to recognize objects placed in his hand.

5. Speech.

When the paralysis affects the dominant hand, that is, the one he uses to write, then we may expect the patient to have a language problem (aphasia). As 96 per cent of the population are right-handed, we may expect those with a right hemiplegia to have aphasia.

There is nothing as frustrating as being unable to express one's self. The evaluation of the type of aphasia is essential before therapy is started. There are four types of aphasia: motor, expressive, motor-expressive and global. A special booklet describing the problem for the patient and his family has been prepared and a method of treating the patient by a member of the family.[1]

Conclusions

The rehabilitation of the hemiplegic patient should begin as soon as definitive care is no longer required. This, in most cases, can be started 48 hours after the "stroke." If the patient is waited upon by the nurse and his family over a period of time it is extremely difficult to get him interested in helping himself.

The objectives of the program are to begin ambulation, with the aid of a short leg brace and cane; to teach the patient to perform self-care activities with the unaffected hand; to treat the affected leg and arm in order to prevent deformities, and re-educate the affected muscles and to give speech therapy if aphasia is present.

1. Taylor, Martha L.: Understanding Aphasia, Institute of Physical Medicine and Rehabilitation, 400 East 34th Street, New York, New York.

New York University
Bellevue Medical Center
400 East 34th, New York, New York

MEDICAL CENTER

Message from the Dean

The Department of Dietetics at the University of Oklahoma Medical Center has a dual responsibility: dietary treatment of the patient and teaching the objectives of dietary therapy to professional personnel. The patient is the department's primary reason for existence. The interpretation of the dietary physiologic and psychologic needs of the patient to insure maximal contribution to his recovery and sustained rehabilitation in the community is a constant challenge to the dietitian.

It is the dietitian's responsibility to adapt the diet for the individual patient from the physician's prescription. In order to accomplish this effectively she must develop an understanding of the patient and his social, religious and economic influences. She must educate the patient and family members when possible. She must gain the patient's cooperation and motivate him to adhere to the prescribed diet while in the hospital and following discharge.

Personal contact between the patient and members of the dietetics staff—the dietitian, dietetic intern, food service supervisors and dietary aides—is necessary for progressive patient education. At the University of Oklahoma Medical Center, a decentralized food service makes this relationship possible. In a decentralized food service, all food is prepared in the central kitchen and transferred by conveyors (heated for hot food) to the ward serving kitchens. There are six ward serving kitchens at the University Hospital and five at Children's Memorial Hospital. The food is selected in the ward kitchens according to the individual patient's diet prescription and served to the patient by the dietary aide.

The Department of Dietetics also operates a milk formula laboratory at Children's Memorial Hospital, a personnel cafeteria and a doctors' dining room at University Hospital. The personnel cafeteria is open 21 hours a day and the doctors' dining room serves the noon meal Monday through Friday. Buffets, coffees and teas are frequently prepared and served to honor special guests and visitors at the Medical Center. Also, food is prepared in the University Hospital Central Kitchen for patients not on metabolic diets at the Oklahoma Medical Research Institute hospital and for children not on formulas in the preschool nursery at University. Throughout all these preparations the dietitian must apply her knowledge of group feeding to provide sufficiently varied menus to appeal to this diverse group.

The Department's teaching responsibilities are to the dietetic interns, medical students, house staff, medical staff, nursing service staff, student nurses, patients (on both an inpatient and outpatient basis), and to employees. Members of the department also participate actively in community health education. The dietitian supervises the diet therapy practice experience for the student nurses and participates in the formal and informal teaching of medical students as well as in in-service education and on-the-job training for non-professional supervisors and employees.

Mark R Everett

Acute systemic allergic reactions may cause minor changes in the electrocardiogram. These may be important in your interpretations.

Electrocardiographic Changes in Acute Allergic Reactions

JERRY R. NIDA, M.D.*

ALLAN J. STANLEY, Ph.D.

Jerry Raymond Nida, M.D., graduated from the University of Oklahoma School of Medicine in 1960. He is now interning at the University Hospital, Oklahoma City.

Allan J. Stanley received his Ph. D. degree from the University of Iowa in 1936. He is professor of Physiology at the University of Oklahoma School of Medicine.

Doctor Stanley is a member of the Society for Experimental Biology and Medicine, the Endocrine Society, Sigma XI, the Oklahoma Academy of Science and an associate member of the American Association for Cancer Research.

ELECTROCARDIOGRAPHIC CHANGES in experimental anaphylactic reactions in rabbits and dogs were recorded in 1951 by Mikulicich. He described extrasystoles, tachycardia, inversion of T waves, inversion of the QRS complex and q-t segment depressions similar to those seen in myocardial infarction. Coca, in his book *The Pulse Test*, used the finding of an increased cardiac rate as a clue to exposure to allergic agents. He had noticed this change first in 1937 while testing his wife for a food allergy. Roth found that nicotine administered both intravenously and by the smoking of tobacco caused an increased cardiac rate and T-wave inversion. Graybiel and White noticed that tobacco smoke caused an increased cardiac rate and depression of the T wave. They suggest that the pharmacological effect of nicotine might be the cause.

We have studied the electrocardiographic changes in the less severe allergic reactions. A series of patients who had previously exhibited food and inhalant sensitivities were challenged by a known allergen and an electrocardiogram was made. It has been recognized generally that smooth muscle in the lungs and digestive tract will react to inhalant and ingested antigens. It seems reasonable that the smooth muscle surrounding the vessels in the myocardium may also react to antigenic substances. Another possibility is neuromuscular hypersensitivity in the conducting system of the heart. This hypersensitivity may involve the SA node,

*Doctor Nida was an Allergy Foundation of America Fellow during the academic year 1959-60 and gratefully acknowledges their financial support for this study.

a manner as to produce electrocardiographic changes.

Technique

A General Electric Cardioscribe and a Burdick Electrocardiograph were used in these experiments. Most subjects had a known allergy established by studies in the Veterans Administration Experimental Unit or in the Oklahoma Allergy Clinic in Oklahoma City, Oklahoma. Pollens were administered by either dispersion into an air tight room and recirculated or by placing a micro amount directly into the nostrils on a vibrating spatula. A control was taken immediately before challenge and a tracing was made as the patient reacted by sneezing, scratching the nose, or rhinorrhea. Foods were given after 12 hours of fasting and a record made when the cardiac rate increased or after one and two hours. Tobacco was tested with both filtered and non-filtered cigarettes.

In most cases the standard limb leads were used. These were sufficient to detect changes in rhythm and rate. Several full tracings were made, but rarely did it contribute more information. All tracings were made with the patient recumbent. The patients were well informed and relaxed to avoid psychophysiological factors. Most tests were made in the months of December, January and February when pollen counts were lowest.

None of these patients have ever had asthma, rheumatic heart disease, coronary insufficiency or histories of myocardial ischemia. Electrocardiograms were analyzed using the standard texts of Burch & Winsor, and Wolff as references.

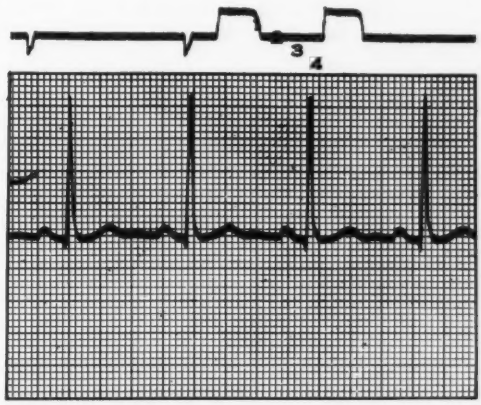
RESULTS

Patient	Allergen	Summary of Results
SM	Triple Ragweed	Increased Cardiac Rate
BM	Triple Ragweed	Increased CR
CS	Triple Ragweed	Increased CR
RG	Triple Ragweed	Increased CR, Minor T-wave changes
AS	Tobacco	Increased CR, T-wave changes
RS	Tobacco smoke	Increased CR, T-wave changes
CF	Tobacco smoke	Increased CR
GW	Banana	Consistent Fast CR 100
JO	Chinese Elm Pollen	Nodal Extrasystoles
ON	Egg Albumen	Minor T-wave changes
OF	Giant Ragweed	Minor T-wave changes
PF	Giant Ragweed	T-wave changes
LK	Giant Ragweed	Minor T-wave changes
KK	Giant Ragweed	Increased CR, T and S-wave changes 80-100
RN	Giant Ragweed	Increased CR 80-100

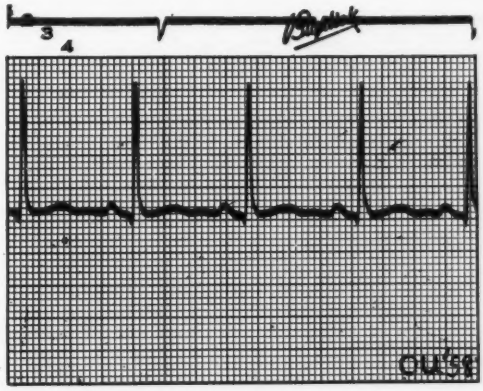
Discussion

Many patients exhibited no symptoms after challenge with the antigen, however, minor changes occurred on the tracings. Many patients had an increase in pulse rate soon after exposure but the constitutional

Ragweed Pollen Sensitivity



Control—Patient R.G.
Cardiac Rate: 80/minute



Test—Patient R.G.
Cardiac Rate: 100/minute

Figure 1.

symptoms were delayed 8 to 10 hours. Control "normal" individuals change very slightly in cardiac rate.

Cases

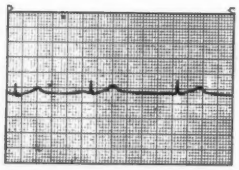
RG is a 25 year old student who had seasonal rhinitis and rhinorrhea. Skin tests show 4 plus reaction to the grasses, especially bermuda, and the ragweeds. Control pulse was 80/minute and after the test with triple ragweed (Giant, short and western), he quickly developed rhinorrhea, pale swollen mucous membranes, conjunctivitis and a pulse of 100/minute. Minor T-wave depression was also present.

RS is a 27 year old student who had chronic "sinusitis." He was tested with tobacco smoke and reacted more than any of the others tested. His cardiac rate was 65/minute initially, but rose to 95/minute after challenge. Some decrease in nasal stuffiness and postnasal drip resulted from "cutting down" on smoking.

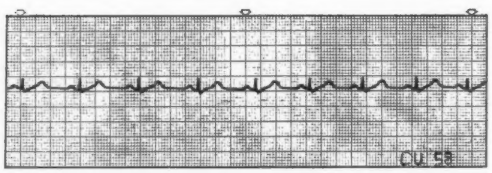
JO is a physician who as a medical student applied for an insurance policy that required a physical examination taken in the spring. He was told of some extrasystoles. When we saw him in December, he had no premature beats. Because of the symptoms only in late February and March, Chinese Elm pollen was tried. Chinese Elm pollen-ates during those months. In about four minutes (tested in December), he developed extrasystoles at a rate of 5-8/minute. The nostrils were quickly lavaged and antihistamines were taken. That evening he had rhinorrhea, itching of the nose, conjunctivitis which was gone the next morning. After four days, he had three extrasystoles per minute. In three weeks there were no extrasystoles. This was the most "spectacular" reaction to any of our tests. Communication with two other physicians have revealed essential identical reaction to pimientos in one case and egg albumin in the other. These cases are several hundred miles from Oklahoma City and recorded proof is not available.

ON is a 52 year old salesman who developed a reaction to polyvalent flu vaccine cultured on eggs. He had an elevated temperature, erythema and swelling in his left arm. A week after symptoms left, he chanced to eat an egg which resulted in "indigestion" and a generalized skin rash without hives. This happened one other time, but the attack seemed to be less serious. By the time of the test only minor T-wave changes were found. Previous pulse tests a month earlier show an increase from 68 to 76/minute in the cardiac rate after

Tobacco Smoke Sensitivity



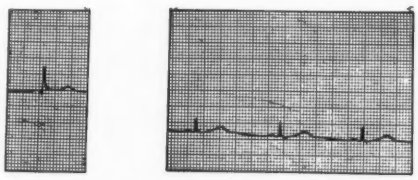
Control—Patient R.S.
Cardiac Rate: 65/minute



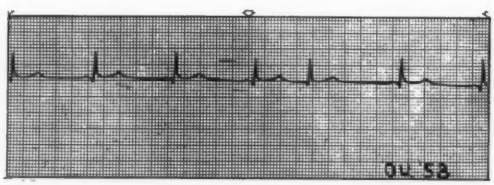
Test—Patient R.S.
Cardiac Rate: 95/minute

Figure 2.

Chinese Elm Pollen Sensitivity



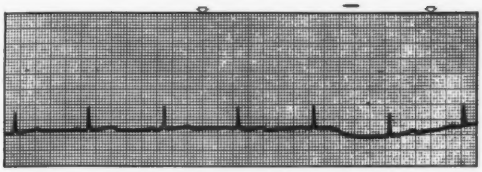
Control—Patient J.O.



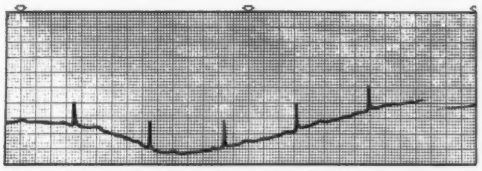
Test—Patient J.O. (note the example of an extrasystole, probably nodal type)

Figure 3.

Hen Egg Sensitivity



Control—Patient O.N.



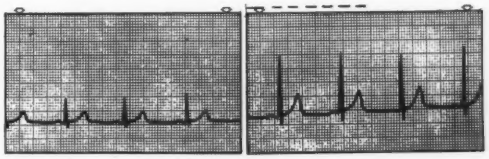
Test—Patient O.N. (Minor T-Wave changes are noted)

Figure 4.

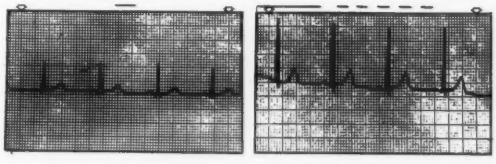
one challenge and from 72 to 80/minute on another occasion. A gradually increasing egg diet has increased his tolerance.

KK is a 22 year old student who has been found sensitive to house dust and ragweed pollen by skin testing. His electrocardiogram shows a slight increase in cardiac rate and also a depression of the T wave. Precordial leads show minor S-wave changes. All of these findings suggest anoxic changes.

Giant Ragweed Pollen Sensitivity



Control—Patient K.K.
Cardiac Rate: 80/minute



Test—Patient K.K.
Cardiac Rate: 100/minute (note T-Wave depression)

Figure 5.

The ragweed sensitive group exhibits the typical increase in cardiac rate, as Coca first reported in 1937. There is electrocardiographic proof that the rate increases and that there are only other minor changes. The T-wave depression suggests very slight myocardial anoxia in the repolarization phase. The problem is still unsolved as to the exact site of the reaction. One can suspect the smooth muscle around the pulmonary bronchi as well as in the coronary artery. Both may give this picture.

There is some doubt in those tested with tobacco smoke, if the result was due to a true antigen-antibody reaction or to the nicotine. Graybiel, White and Roth have recognized tachycardia and T-wave depression as the nicotine effect. In our small series T-wave depression was lacking and in the case previously mentioned, it was actually elevated 1 to 2 mm. These cases deliberately chosen because of allergic histories, may represent tobacco allergy instead of the pharmacologic nicotine response.

One patient tested was allergic to bananas. Her normal daily pulse was about 76/minute. On the day she was tested to banana there was a constant rate 100/minute. After the electrocardiogram was analyzed, a letter was sent to find out if she had eaten anything before the test. She admitted eating a biscuit that morning. Examination of her old skin test record shows a moderate reaction to wheat. Two hours after the ingestion of the banana she developed a migrain headache, and 16 hours later she had diarrhea.

Conclusions and Summary

Minor cardiac irregularities exist in allergic individuals following a challenge by the antigenic agent. Increased cardiac rate, extrasystoles and T-wave changes have been shown. We have not found a specific change that can be related to the acute allergic reaction except an increase in the cardiac rate that can also be detected simply by feeling the pulse. The underlying physiologic basis is still unknown. Experiments to determine if these changes are primary to the respira-

tory or the cardiovascular system are planned.

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800 NE 13th, Oklahoma City, Oklahoma

ABSTRACTS

The Influence of Clorpactin WCS-90 on the Bacterial Complications of Surgery

M. K. DuVAL* and F. H. HOWARD.**

Surgery 47: 210-216, Feb. 1960.

A study of the effects of Clorpactin WCS-90, a nontoxic, nonallergic, water-soluble monoxychlorosene, in preparing the skin and irrigating the wound at the time of operation, was made over a period of one year and included 1,000 patients. The series comprised 533 males and 467 females of all ages, from newborn infants to octogenarians. The experimental group was composed of 489 patients, in whom the skin at the site of operation was scrubbed for 5 minutes with a 4% Clorpactin WCS-90 solution in distilled water; as the operation proceeded, the wound was irrigated for a full minute with 300 cc. of the Clorpactin solution once every hour and again at the time of wound closure. In some cases irrigation of the peritoneal or the pleural cavity was done. Nondrained operative wounds were covered with sterile dressings for 47 to 72 hours, and then left exposed. The control group was composed of 511 patients, who underwent the same procedure, with use of a surgical soap containing hexachlorophene for scrubbing the skin and sterile sodium hydrochloride solution for irrigating the wound.

There were 262 "clean" and 249 "contaminated" patients in the hexachlorophene-treated group, 275 "clean" and 214 "contaminated" patients in the Clorpactin-treated group. The incidence of wound infection was 4.6% in the clean and 9.8% in the contaminated patients of the control group, while in the experimental group these percentages were, respectively, 1.8 and 7.5%. Although the difference is not statistically significant, there is evidence of a protective effect of Clorpactin. Further observations showed that, when the contact time with Clorpactin during the irrigation of the wound is increased from 1 to 3 minutes, the rate of protection also increases. One significant difference was that in the Clorpactin series 75% of the infections occurred either in cases of peripheral vascular surgery, in which the blood supply was insufficient, or in cholecystectomies. This limitation of infection was not noted in the control group. The failure of preventing infection in peripheral vascular operations justifies the inference that no agent can be a substitute for good surgical technique and gentleness in handling tissue, especially in situations of compromised blood supply.

*Associate Professor of Surgery.
**Resident in Surgery.

Maintenance of Pulmonary Arterial Medial Hypertrophy in Newborn Pups

GILBERT S. CAMPBELL,* WILLIAM E. JAQUES,** and DAVID D. SNYDER.***

Surgical Forum, **Vol. X**, 1960

A post-ductal coarctation was produced in newborn pups and the physiologic and anatomical pulmonary changes were compared with non-coarctated controls.

Non-coarctated pups showed a regression in right ventricular pressure and pulmonary arteriolar medial mass whereas coarctated pups had persistent right ventricular hypertension and persistent fetal medial hypertrophy in the pulmonary arterioles.

*Professor of Surgery.
**Professor of Pathology.
***Resident in Surgery.

The Physiologic Effects of Dexamethasone

KELLY M. WEST,* PHILIP C. JOHNSON,** ADRIAN A. KYRIAKOPOULOS,*** W. JULIAN BAHR**** and CARMEN E. BLOEDOW.*****

Arthritis and Rheumatism, 3: 129-139, April 1960

The hyperglycemic and eosinopenic potencies of dexamethasone were determined in man and were found to be essentially identical to the anti-inflammatory potency of this drug (approximately 25 to 30 times that of hydrocortisone).

Under the conditions of our experiments we were unable to establish precisely the potency of dexamethasone in suppressing corticotropin. However, the data suggest that in man the potency of dexamethasone in this respect is roughly equivalent to its potency in producing hyperglycemia, eosinopenia and suppression of inflammation.

Under the conditions of our studies (2 days of therapy), antidiuresis of water, sodium and chloride excretion occurred after the administration of hydrocortisone, while prednisolone produced an equivocal diuresis of water, sodium and chloride. Dexamethasome produced an antidiuresis of sodium, chloride and water of equivocal significance. Hydrocortisone, prednisolone and dexamethasone all produced a diuresis of potassium when the drugs were administered in doses of comparable anti-inflammatory potency. The potassium diuresis produced was less during therapy with prednisolone than during therapy with the 2 other drugs.

None of these 3 drugs affected the urinary excretion of magnesium.

*Assistant Professor of Medicine.
**Associate Professor of Medicine.
***Research Fellow in Medicine.
****Resident in Medicine, University Hospital.
*****Chief Resident in Medicine, V. A. Hospital.

Vascular Lesion of Hereditary Hemorrhagic Telangiectasia

ROBERT M. BIRD* and WILLIAM E. JAQUES**

N. Eng. J. Med. 260: 597-9, March 1959

A clinical and pathological study on an elderly man with hereditary hemorrhagic telangiectasia is presented. The findings emphasize the fact that the telangiectasia involved large and small veins primarily. Arterial involvement was inconspicuous. All major organ systems were involved, and in each the venous defect was diffusely distributed. Clinical bleeding seemed to depend more on chance or accessibility of a tissue to trauma than on any predilection of the disease for a particular organ system. It is suggested that the cardiovascular disease resulted from the presence of increased numbers of arteriovenous communications.

*Associate Professor of Medicine and Physiology.
**Professor of Pathology.

Pulmonary Hypertension and Plasma Thromboplastin-Antecedent Deficiency in Dogs

WILLIAM E. JAQUES,* JAMES W. HAMPTON,** ROBERT M. BIRD,*** KARL A. BOLTEN**** and B. RANDOLPH.*****

A.M.A. Archives of Pathology, 69: 248-256, 1960

Dogs infused with autologous, homologous, and human amniotic fluid rapidly developed pulmonary hypertension without regard for the sex of the animal or the source of the fluid. The pressures in the lesser circulation increased progressively with repeated infusions.

Fibrin thrombi in varying stages of organization were demonstrated in the pulmonary vascular bed.

The animals given infusions of amniotic fluid consistently showed a prompt fall in fibrinogen and developed a defect in thromboplastin generation. This deficiency in thromboplastin generation was shown to be functionally similar to plasma thromboplastin-antecedent (PTA) deficiency in man.

*Professor of Pathology.
**Public Health Service Trainee and Clinical Assistant in Medicine.
***Asociate Professor of Medicine and Physiology.
****Research Associate in Pathology.
*****Technician in Medicine.

Symposium on Hereditary Metabolic Diseases Galactosemia

HENRY N. KIRKMAN.*

Metabolism 9: 316-325, April 1960

Galactosemia is an autosomal, recessive disease in which the affected individual lacks active ∂-D-galactose-1-phosphate (Gal-1-P) uridyl transferase, one of the enzymes necessary for galactose utilization of galactose. This lack leads to an accumulation of galactose-1-phosphate, which in turn causes cellular injury. The signs of the fully manifested disease are jaundice, hepatomegaly, cirrhosis, cataracts, galacturia, aminoaciduria and failure to grow. Death sometimes results. In the severe form of this disease, symptoms occur soon after birth; but milder forms may escape detection until late infancy or childhood. These complications, and possibly the mental deficiency that often present later, can be prevented by the early dietary exclusion of galactose, which is found predominantly in milk. In heterogygous individuals Gal-1-P uridyl tranferase activity is moderately reduced, but they usually show none of the signs of the disease. The various technics of measuring the abnormal galactose metabolism are summarized.

*Assistant Professor of Pediatrics.

Two Associate Deans Named

Two new associate deans have taken office at the University of Oklahoma School of Medicine, filling vacancies left by Kirk T. Mosley, M.D., D.P.H., new Oklahoma state commissioner of health, and A. N. Taylor, Ph.D., who quit August 1 to become an assistant secretary with AMA's Council on Medical Education and Hospitals in Chicago.

WHITE

Joseph M. White Jr., M.D., head of the Department of Anesthesiology since 1956, was named associate dean in charge of special training and research programs, the title formerly held by Doctor Mosley.

Doctor Taylor's successor is associate dean in charge of student affairs is Philip E. Smith, D.Sc., professor of preventive medicine and public health and director of the Medical Center division of the OU Graduate College.

SMITH

Doctor White is a graduate of Southwestern Medical School, Dallas, Texas. He interned at Denver General Hospital, took residency training at the University of Iowa Hospitals and received a Master of Science degree in pharmacology at the University of Iowa School of Medicine.

He was in private practice in San Francisco, served with the army in Korea and Japan from 1952 to 1954, and was assistant professor of anesthesiology at the University of Washington School of Medicine, Seattle, before coming here. He will continue to handle departmental duties.

Doctor Smith, a faculty member since 1952, holds a Master of Science degree from the University of Illinois and a Doctor of Science from the Johns Hopkins University School of Hygiene and Public Health. The new associate dean taught in the zoology department at Oklahoma State University prior to joining the OU medical faculty.

He is president of Oklahoma Academy of Science and has held other state offices in that organization since 1955. He has the rank of Major, Medical Service Corps, U.S. Army Reserve.

Doctor Taylor left the Medical Center after 14 years service, coming here from the physiology department of the University of Texas Medical Branch, Galveston. He was chairman of the OU Department of Physiology and had been associate dean of students eight years. M. Jack Keyl, Ph.D., assistant professor, is currently heading the physiology department as vice chairman.

At the AMA Council office, Doctor Taylor will be responsible for establishing a new division to develop liaison between medicine and the allied health professions.

The School of Medicine now has three associate deanships. The third is occupied by S. N. Stone, M.D., in charge of clinical instruction.

Newest of the administrative positions is the one taken by Doctor White. Doctor Mosley was named first dean in charge of special research and training programs when the post was created in January, 1958 to keep pace with growth of the institutions.

Doctor Mosley, on the faculty since 1952, assumed duties as health commissioner July 1. He continues to hold the appointment of professor of preventive medicine and public health.

Eight Faculty Appointments Approved by Regents

Eight appointments to the School of Medicine faculty have been approved at recent meetings of University of Oklahoma Regents.

Anton Lindner, M.D., new chief of clinical laboratories at the Oklahoma City VA Hospital, was named associate professor of pathology, and Robert E. Coalson, Ph.D., who completed his graduate training in medical sciences at the OU Medical Center in 1955, has returned as assistant professor of anatomy.

Others include three instructors in pediatrics, two clinical assistants in medicine and an assistant professor of audiology in the Speech and Hearing division.

Doctor Lindner came here from the VA Hospital at Buffalo, where he also was an assistant professor of pathology at the University of Buffalo. His previous academic appointments were at the University of Wisconsin, the University of Innsbruck, Austria, where he received his M.D. degree in 1941, and the University of Chicago.

The pathologist interned at St. Louis University, took his residency work at the University of Graz and Vienna City Hospital in Austria, Cook County Hospital in Chicago and McGill University in Montreal.

Doctor Coalson, the new anatomy teacher, has served as biochemistry assistant, Brooke Army Medical Center, Fort Sam Houston, Texas, and as instructor in anatomy at Vanderbilt and special instructor in anatomy at Meharry Medical College, Nashville.

New pediatrics instructors are Jimmy L. Simon, M.D., former chief of pediatrics at Tinker Air Force Base, Robert Emmett Myers, M.D., and Jacob L. Kay, M.D., who recently completed a fellowship on the newborn service at Baylor University College of Medicine.

Doctor Simon is a graduate of University of California School of Medicine. He served a pediatric internship at the University of California Hospital and took residency training at Grace New Haven Hospital and Boston Children's Hospitals.

Doctor Myers, a 1955 graduate of the University of Arkansas School of Medicine, interned at Cleveland City Hospitals and completed his residency at University Hospitals of Cleveland.

Doctor Kay holds an M.D. from Baylor University College of Medicine and interned at Houston's Jefferson Davis Hospital. He also did his residency training at Baylor, took advanced work in care of the newborn and premature as a fellow at Boston Lying-in Hospital returning then to Baylor.

Named clinical assistants in medicine were James W. Hampton, M.D., and Gerald Honick, M.D., both OU medical graduates who have been taking advanced training at the Medical Center.

Doctor Hampton interned at University Hospitals, remained at the Center for a residency in medicine and has been a hematology fellow the past year. Doctor Honick also interned and was a resident in medicine at the Medical Center. A research fellow in cardiology the past year, he will have part-time teaching duties.

The new speech and hearing staff member is Howard Bernard Ruhm, Ph.D., who will direct audiological research in that division. He was graduated from George Washington University, received his master's degree from the University of Maryland and his Ph.D. at Northwestern University. He spent four years as an audiologist with the Veterans Administration.

Speech and Hearing Clinic To Have New Wing

Ground was broken this summer for a two-story, $172,936 addition to the University of Oklahoma Speech and Hearing Clinic at the OU Medical Center.

The wing will provide additional facilities for teaching the deaf and hard-of-hearing, for speech therapy and graduate instruction and research in audiology and speech therapy. Construction funds were provided by a Hill-Burton federal health facilities grant matched by an appropriation from the last legislature.

University Regents at their June meeting transferred administration of the Clinic from the College of Arts and Sciences on the Norman campus to the Medical Center, making it a "division" and integral part of the Center. The present clinic building was opened in 1957.

Special Article

Hailed as the nation's finest, OU's adult education center begins new era in regional adult education.

Oklahoma Center For Continuing Education

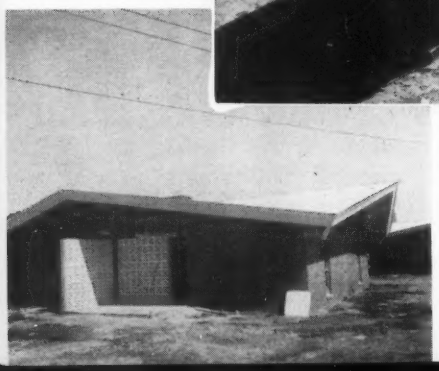
UNIQUE IN DESIGN, comprehensive in programming; developed to serve the dynamic patterns of adult concerns in Oklahoma and the Southwest.

This, very simply, describes the new Oklahoma Center for Continuing Education, which promises to open a new era in regional adult education.

Now under construction on the southwest corner of the University of Oklahoma campus in Norman, the Oklahoma Center will lose no time in establishing a bid as the focal point for regional Continuing Education.

To the Center will be drawn human resources of Oklahoma and the region, there to enjoy the benefits of the complete educational resources of the University.

Pictured right is the Forum, hub of the Center, which is now nearing completion.



At left is seen one of the ten duplex family cottages, each housing eight persons.

Here more than 60,000 adults from Oklahoma and surrounding states will gather each year to participate in specific areas of study, designed to help each individual Learn a Better Living—economically and culturally.

Kellogg Project

Partially financed by a $1,845,000 grant from the W. K. Kellogg Foundation, Battle Creek, Michigan, the $4 million plant will offer the nation's finest facility for Continuing Education.

Dr. George L. Cross, University president, Dr. Thur-

Housing Unit 1, pictured above, will provide air-conditioned housing for 152 adult education students. Each floor has a lounge for formal or informal get togethers. Single or twin bedrooms are available.

man White, dean of the University Extension Division, faculty members and extension personnel are presently engaged in shaping the calendar of programs for which the physical plant was built.

Expanded Program

Starting with one of the nation's foremost extension programs, which presently attracts 35,000 men, women and teenagers to the University campus each year for some 240 events, extension directors and specialists are concentrating their efforts on expanding old programs and developing new ones to fit growing regional needs.

The needs of Oklahoma adults, Dean White emphasizes, have always guided and will continue to determine the type of services offered by the University Extension Division.

When the Oklahoma Center for Continuing Education opens its doors for business — estimates range from 12 to 20 months hence — adult patrons will find a "customer's market."

There'll be something for everyone who desires to participate in higher adult education at this modern educational facility; everything that can be provided by total resources of a great state university, supported by knowledge and skills of state and national leaders in all fields of knowledge.

Business, industry, the professions, education, government and just plain John Q. Citizen will find the new facility and the people who operate it ready to serve all appropriate requests.

University faculty members and extension specialists are on call as consultants, ready to help plan, develop and conduct programs to fit individual and group needs.

One of five Kellogg-supported Centers for Continuing Education, the Oklahoma Center differs structurally from the other four, and its approach to Continuing Education for the region's adult population offers a unique pattern.

Where Centers at Michigan State, the University of Georgia, Chicago University and the University of Nebraska are housed in a single building, the Oklahoma Center will be made up of a complex of five major buildings and 10 duplex family cottages.

Facility Described

Located on a 20-acre tract west of Cross Center and bordering Sooner City to the south, the complex is designed for:

The intellectual headquarters of the University's adult student body;

An aesthetic and cultural setting, free from ordinary distractions, to provide privacy for individual thought and study within an optimum environment for group learning;

A setting to further democratic values in group and inter-group relations;

Provision of a variety of adult learning methods and materials.

The Forum, hub of the Center, will provide 21 conference rooms, ranging in capacity from 25 to 526, with an overall capacity of 1,776.

Air-conditioned for summer programs and forced air heated for winter months, meeting rooms will provide maximum comfort, with individual desks and swivel chairs.

Arrangement of these hexagonal meeting rooms also assures the necessary degree of isolation for development of group processes and concentrated study within the group.

Two large discussion type meeting rooms, one seating 200 the other 526, offer large group space needed for lecture demonstrations and exhibits, while retaining the acoustical balance of smaller meeting rooms.

The larger room, the Assembly Room, is built around a 26-foot circular, hydraulic stage, that may be lowered to the basement for loading. Any of the 526 students may speak in a normal tone and be clearly heard by the lecturer on stage or a fellow student across the room.

Convenient to the adult student also will be the Center library, located in open stacks in the Forum. Students will have a choice of several thousand volumes, a good many of which will deal with highly specialized subject matter.

The Center is fully supported by the University's 750,000-volume Bizzell Memorial library, and will have available to its adult students the assistance of research scholars on campus.

Excellent Housing

Center housing for the adult student offers a variety of choices.

Housing Unit I, a three-story dormitory, will offer air-conditioned comfort for 152 students.

Twenty-four twin bedrooms on each floor will house 144 persons and eight single rooms on the second and third floors bring the total to 152.

Each floor is equipped with a comfortable lounge for informal conversations and small discussion groups.

Housing Unit II (Hall of Advanced Studies) is a six-story structure designed for closely identified groups and limited to 40 persons.

Each floor above the ground level, two through five, will be composed of two living areas, with four bedrooms adjoining each small sitting room.

A meeting room on the ground floor, with seating arranged to cover half the room, will provide conference space for 40 persons.

Intensive study groups in the Hall of Advanced Studies may take advantage of meal service in a ground floor combination lounge-dining room, suitable for small banquets and private luncheons.

Guests will also have use of a small kitchen, for snacks or to give the amateur chef full latitude in displaying his culinary abilities.

For the student who wishes to combine a period of study with a trip for the family, the Center will offer 10 comfortable, air-conditioned duplex family cottages, each housing eight people.

Each of the 20 units will provide a living room, dining room, kitchen, two bedrooms and bath, a total of 875 square feet of floor space per unit.

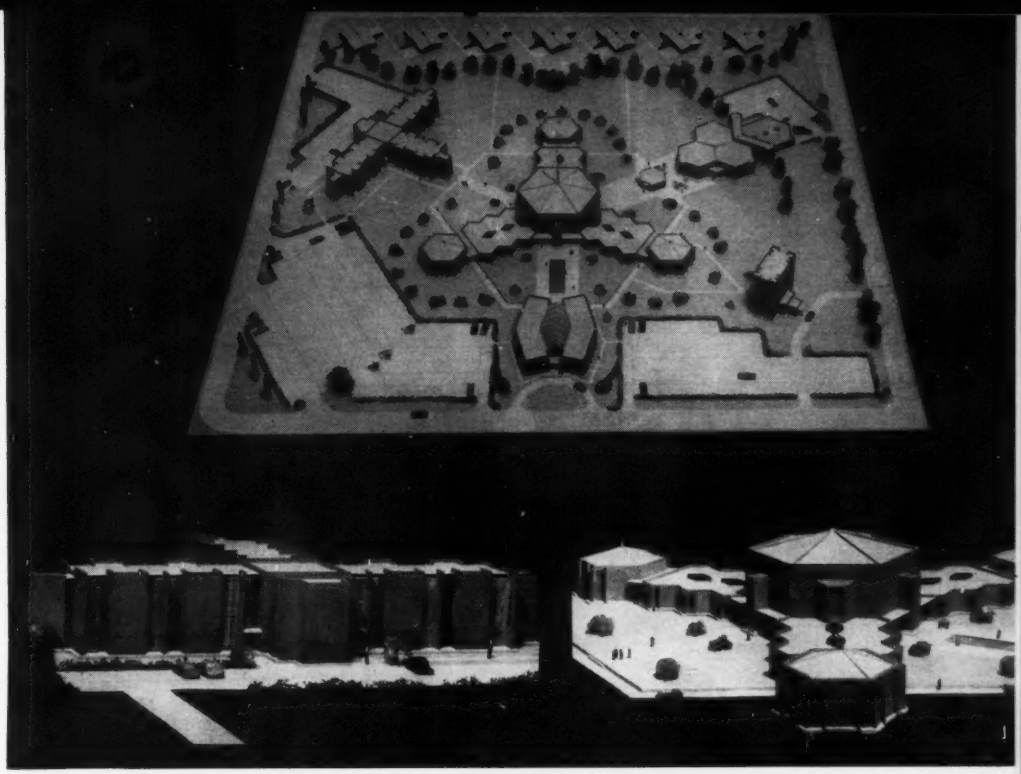
Kitchen equipment includes an apartment range, refrigerator, cabinets, and double sink. The dining area seats six.

Living rooms will be furnished with a sofa bed (raising the sleeping capacity of each unit to six), easy chairs, occasional chairs, coffee table, floor lamps and television.

With its superb housing facilities the Center will offer its students and visitors a cuisine of equal excellence in its new cafeteria.

Cafeteria patrons will have a choice of three dining rooms, each seating 200. Four private dining rooms, each seating 20, will be available for small groups.

The three large dining rooms may be converted into a banquet room, seating 600 guests.



The plot plan of the entire center is shown above. Duplex housing units are on the rear property line and the Forum (center) is surrounded by Housing Unit I (upper left), Cafeteria (upper right), Housing Unit II (lower right) and the Administration Building (foreground, between parking lots). Housing Unit I and the Forum appear at the bottom of the illustration.

Housing and meal costs, not determined at present, will be held to a minimum, with food prices in keeping with those of other University facilities.

The fifth major structure, the Center administration building, will house extension personnel and student records.

A source of funds for the $500,000 building has not yet been found, but is hoped that money for the building will be provided through private resources.

Welcome news to the adult student is word that ample parking facilities will be available on and around the Center. Plans call for parking areas adjacent to both housing units and family cottages and within easy walking distance of the Forum and cafeteria.

Recreation for Students

Also proposed for the Center landscaping program are such recreational features as a putting green and horseshoe, volleyball, badminton and croquet courts.

University tennis courts, swimming pools and the golf course will also be open to Center students.

With this unique facility soon to be ready for Oklahomans and their Southwestern neighbors, University leaders see the day when the Center will become the intellectual home of thousands of adults from the Southwest; men and women who take advantage of Center offerings as a means of enriching their lives as the years bring new interests.

For this overall pattern of human advancement, the Center will house a comprehensive program of short courses, conferences, workshops, seminars, institutes, classwork, study discussion groups and home studies in the following areas:

Common learnings, or programs of general education; professional programs, or college level vocational education; civic and social learnings; health; home and family life education, and cultural and interpretive studies.

Community of Learning

Setting the Oklahoma Center apart from

other university Centers for Continuing Education are two programs unique in the field of adult education:

1. Emphasis on the value of adult students working and living in a "Community in Miniature;"

2. Establishment of an adult student body, based on the individual's lifelong participation in Continuing Education programs at the Center.

First in the nation to recognize and adopt the "Community in Miniature" method of bringing about a closer relationship between adults, the Center program proposes to bring the various groups into contact through plannned leisure-time activities, and through programs of common learnings and liberal education.

While the design of Center housing insures necessary group isolation for concentrated study, opportunities are also provided for inter-group relations at appropriate times.

The Center, a "Community in Miniature," will extract certain essential features from the larger community—from which the students come—and reproduce them within the complex.

Government activities, housing, services, recreation and other large community processes will be integrated into life of the miniature community within the Center.

Representatives of each conference group will have a place on the Center's Community Council, to plan evening programs of Center-wide interest and assist in maintaining liaison between students and professional members of the Center staff.

Through this medium, then, the professional man and the man who works with his hands, the employer and the employe, the adult and the youngster may engage in a free flow of ideas, and all may benefit.

To encourage lifelong planning of Continuing Education, the Center will provide a central records system and a testing-counseling service.

Existing records of adult participation in Extension Division programs now embrace a student body of 50,000, many of whom return each year for studies of varying interests.

Courses designed for specific interest groups may be readily filled by students whose records indicate an interest in those particular fields, and extension specialists may find study records helpful in their search for ideas leading to development of new programs.

For the student who is interested in developing a course of study for economic or cultural reasons, a series of tests offer a useful measure of abilities and interests.

Counseling may then be called on to formulate a long-range study program, and the University's finest faculty members will be on hand to guide the student through his chosen curriculum.

Through these services, University leaders believe it is possible to present a practical program of providing "The Whole Truth for the Whole Man Through the Whole Life."

Experimental programs designed specifically for Oklahoma and the Southwest are expected to add materially to the region's economic and cultural growth.

To Offer Medical Education

Of particular interest to the Medical Profession is the proposed closed-circuit television experiment, emaniting from the Medical Center in Oklahoma City.

Plans call for telecasts from the Medical Center to an audience of physicians who might be meeting at the Oklahoma Center, or to individuals in their offices or homes.

Surgery employing the latest techniques, for instance, might be witnessed by surgeons meeting in Norman, with two-way communications making it possible for a member of the audience to ask a question and receive an answer from the operating room.

Para-medical groups, such as physical therapists, laboratory technicians, medical social workers, pharmacists, school health educators, X-ray technicians and others, may also benefit from lectures and demonstrations beamed directly from the Medical Center.

Other programs of equal interest to other professions and groups are being developed, and suggested programs from any organizations are welcomed by extension personnel.

Whatever the idea, if it serves the people of Oklahoma, the University of Oklahoma Extension Division is ready to help in its development and application.

In Acute Illness...

NILEVAR®

Can Speed Recovery

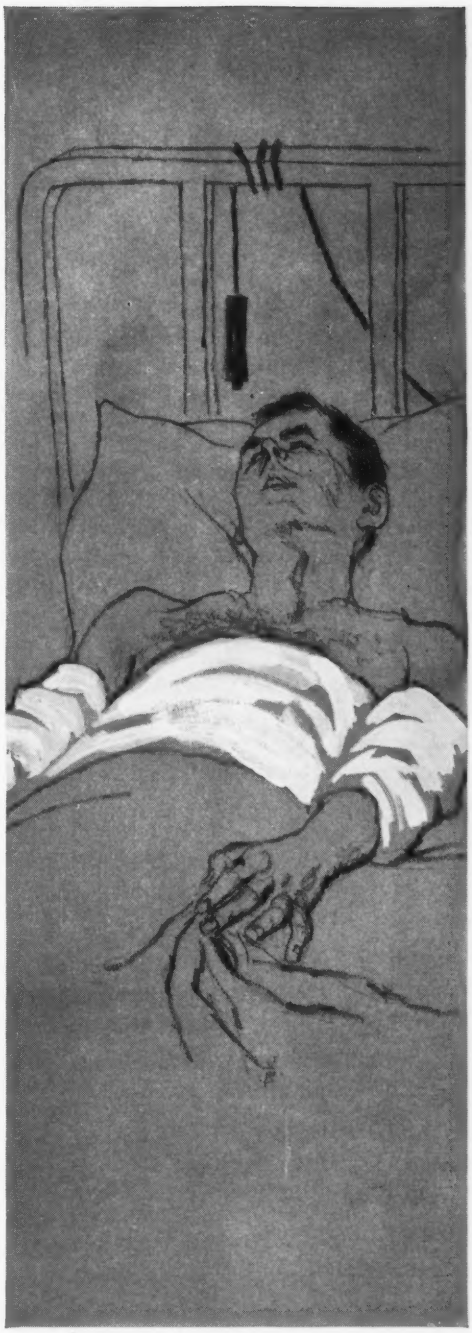
"Commonly, negative nitrogen balance[1] occurs during acute febrile illnesses and following traumatic events and surgical procedures." As much as 300 to 400 Gm. of nitrogen[2] may be destroyed daily in severe infections. Convalescence[1] is delayed when negative nitrogen balance is large and persistent.

NILEVAR Builds Protein, Speeds Convalescence to Complete Recovery[3-6] ". . . we were impressed[3] with the efficacy of Nilevar as an anabolic agent. All of the patients reported feeling much more vigorous and experiencing an increase in appetite. . . ."

The actions of Nilevar[4] in reversing a negative nitrogen balance—and therefore a negative protein balance—improving the appetite and increasing the sense of well-being can be expected to shorten the illness and the convalescence of these patients.

An initial daily dosage of 30 mg. of Nilevar (brand of norethandrolone) is suggested. After one to two weeks, this dosage may be reduced to 10 or 20 mg. daily in accordance with the response of the patient. Continuous courses of therapy should not exceed three months, but may be repeated after rest periods of one month. Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil with benzyl alcohol.

1. Eisen, H. N., and Tabachnick, M.: Protein Metabolism, M. Clin. North America 39:863 (May) 1955. 2. Jamison, R. M.: General Nutritive Deficiency, Virginia M. Month. 83:67 (Feb.) 1956. 3. Goldfarb, A. F.; Napp, E. E.; Stone, M. L.; Zuckerman, M. B., and Simon, J.: The Anabolic Effects of Norethandrolone, a 19-Nortestosterone Derivative, Obst. & Gynec. 11:454 (April) 1958. 4. Batson, R.: Investigator's Report, Feb. 11, 1956. 5. Weston, R. E.; Isaacs, M. C.; Rosenblum, R.; Gibbons, D. M., and Grossman, J.: Metabolic Effects of an Anabolic Steroid, 17-Alpha-Ethyl-17-Hydroxy-Norandrostenone, in Human Subjects, J. Clin. Invest. 35:744 (June) 1956. 6. Brown, C. H.: The Treatment of Acute and Chronic Ulcerative Colitis, Am. Pract. & Digest Treat. 9:405 (March) 1958.



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Research in the Service of Medicine

PRESIDENT'S LETTER

The dull gray skies over Washington were smudged with low hanging clouds as we walked from the parking lot toward the Senate chamber. "You know," said the Senator, "in eastern Oklahoma they would call those clouds 'threatening', but out in New Mexico they call the same clouds 'promising'." Dick Graham and I smiled as once again we acknowledged the wry humor of Senator Robert S. Kerr of Oklahoma.

In a few minutes we were to see him in a different setting and in a different mood in the Senate, as he clashed with Senator Anderson from New Mexico over provisions of the so-called Anderson Amendment to the Mills bill. Congressman Mills' bill in the Senate had evolved into the Kerr bill, and Senator Anderson and his followers wanted to amend it only enough to include a raise in the Social Security tax from both employe and employer of ¼%, a total of ½%, and with this to offer all-inclusive hospitalization and hospital outpatient facilities to all Social Security beneficiaries.

We were privileged to watch and listen from the Senate gallery during the two days and evenings of August 22 and 23 as the plan unfolded in this latest attempt to add medical care to Social Security. Most of the proceedings were dull, but with the tenacious Kerr battling facts with facts and figures with counter figures on the true medical needs of our nation. Debate was so prolonged that a mutual agreement had to be negotiated as to a specific time for a vote Tuesday on the foredoomed Javits amendment, which would have authorized government financing of health insurance, and a vote within four hours after this on the Anderson Amendment. Senator Javits' amendment failed, with only 28 "yea" votes.

We now have 100 duly elected members of the United States Senate, what with the recently admitted states of Alaska and Hawaii. In the final, tense roll call at 6:20 Tuesday evening exactly 51 senators voted against the Anderson amendment.

The Kerr bill has since been submitted to joint conference of the House and Senate, cleared the Rules Committee, and been referred on to the President for signature into the law of the land.

Gentlemen, make no mistake about it, the clouds this year were "threatening."

Walter E. Brown, M.D.

Walter E. Brown, M.D.
President

News

Welfare Department Cuts Medical Fees 10%

Delegates to the Oklahoma State Medical Association assembled at the state headquarters building on July 31st, at which time they learned of a financial crisis in the operation of the Department of Public Welfare's medical care program and were told that a ten per cent cutback in medical care payments would be invoked in August. The ten per cent economy measure would also be applied against other health care vendors, such as hospitals, ambulance services and blood banks.

The announcement was met with mixed emotions, and critics of the program since its inception had opportunity to give vent to their long-standing, philosophical grievances. To such physicians, the cutback was a reflection of the financial plight brought on by predicted expansion of the program beyond its original objectives. To many others, the shaving of fees represented a necessary economy measure, the burden of which should be shared by all persons and institutions rendering care under the program. Regardless of the philosophical outlook, the Welfare Department was faced with an immediate problem of tightening its purse strings until such time as financial balance could be restored.

Less Money: Same Costs

In brief, the Welfare Department reported that expenses were exceeding income. It seems that the maturation of the Social Security program is affecting the transfer of many pensioners from the welfare rolls, thus rendering the Welfare Department ineligible to receive Federal matching funds for these persons and lessening the funds available for the medical care program. While it would be reasonable to expect the expense of purchasing health care for the recipients to decrease proportionately to the decreasing numbers of recipients, such was apparently not the case.

The Delegates' Discussion

The problem was presented to the Delegates by Mark R. Johnson, M.D., Chairman of the OSMA Council on Socio-Economic Activities and member of the Professional Advisory Committee to the Department of Public Welfare. He was assisted in his presentation by President Walter E. Brown, M.D., and others especially familiar with the complexities of the medical care program.

Doctor Johnson pointed out that the OSMA could either arrive at an alternate economy measure or accept the ten per cent reduction in keeping with a pre-existing policy (1959) which provided that such a financial crisis could be met by an across-the-board reduction in vendor payments of all types.

Doctor Johnson moved: *"That the Oklahoma State Medical Association approves the across-the-board reduction in vendor payments in the medical care program by the Department of Public Welfare."* The motion received a second.

Then, E. K. Norfleet, M.D., Bristow, proposed the following substitute motion, which received a second, but was later tabled:

"I move the Oklahoma State Medical Association go on record that it will continue to care for these people regardless of who pays or does not pay, but it is opposed to accepting the reduction in the program."

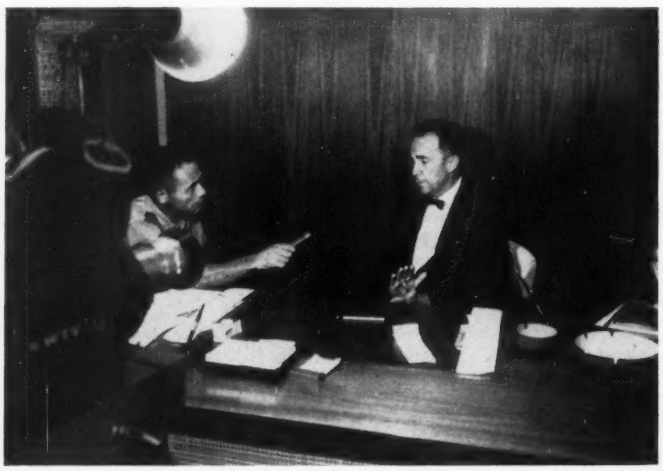
As a counter proposal, Doctor Johnson suggested a resolution (so moved by Francis

Walter E. Brown, M.D., OSMA President from Tulsa, takes the floor before the delegates' assembly. He is shown as he clarified key points in the complex financial structure of the D.P.W. Medical Care Program for Public Assistance Recipients.

Wendell L. Smith, M.D., Tulsa Delegate, Dick Graham, OSMA Executive Secretary, and Jack Spears, Executive Secretary of Tulsa County (left to right) have lively discussion during a break in the meeting. In the background, President Brown.

J. R. Stacy, M.D., (left) Chairman of the Council on Public Policy, is shown conferring with Mark R. Johnson, M.D., OSMA Secretary-Treasurer and Chairman of the Council on Socio-Economic Activities.

Following the meeting, President Brown was interviewed by Oklahoma City's KWTV. The welfare medical care program has always attracted much public interest, and the news services were quick to sound out medicine's views on the current financial situation.



Marshall O. Hart, M.D., presides as Speaker of the House of Delegates, with the able assistance of pinch-hit-secretary Isabell Graham (Mrs. R. H.).

R. First, M.D., Checotah) which criticized previous expansion of the program and called for the cessation of claims for medical care, until such time as the entire plan was re-evaluated and submitted to the physicians for approval. This resolution was put to a vote and lost.

Following a ten minute recess, Speaker of the House Marshall O. Hart, M.D., reconvened the meeting only to discover that a quorum had been lost during the interlude. The meeting was officially adjourned, but recalled by the President in order to test unofficially the sentiment of the Delegates present regarding the principle issue at hand, as well as other matters on the agenda.

After continued discussion of the welfare issue, H. E. Denyer, M.D., Bartlesville, made the following motion which was subsequently approved:

"The Oklahoma State Medical Association regrets that the administration of the Department of Public Welfare finds itself in financial difficulty and states that it will continue to care for the State's poor, and it is sure that administrative changes will be effected to adequately assist physicians and hospitals in carrying the cost of care of the aged sick.

"Further, that a study committee be furnished the Department of Public Welfare in order to develop ways and means for this to be accomplished."

Oklahomans Attend Regional Political Action Conference

French Lick, Indiana was the site of one of three regional meetings sponsored by the AMA's Council on Legislative Activities to review the actions of the 86th Congress with respect to health proposals and to present practical guides and instructions for political organization and action at the local and state levels.

The two-day Political Action Conference was held August 12th and 13th, drawing an attendance of over three hundred persons, representing eighteen states.

John E. McDonald, M.D., member of OSMA's Council on Public Policy, moderated a panel which discussed State Political Action.

Representing Oklahoma, in addition to Doctor McDonald, were Clinton Gallaher, M.D., President-Elect of the Oklahoma State Medical Association; J. R. Stacy, M.D., Chairman of OSMA's Federal Legislative Committee; and Dick Graham, Executive Secretary of Oklahoma State Medical Association.

Committee Chairmen for Annual Meeting Named

Ceylon S. Lewis, Jr., M.D., Tulsa internist, who was named last month by Walter E. Brown, M.D., President of the OSMA, as General Chairman of the 55th Annual Meeting of the Oklahoma State Medical Association, has appointed five Tulsa physicians to serve as sub-committee chairmen.

Those who will serve with Doctor Lewis and Donald L. Brawner, M.D., Tulsa, Chairman of the Scientific Works Committee, will be: E. Malcolm Stokes, M.D., Social Affairs; James W. Kelley, M.D., Golf Tournament; H. Kenneth Ihrig, M.D., Publicity and Press Relations; Robert Jabour, M.D., Commercial Exhibits; and Byron L. Bailey, M. D., Scientific Exhibits.

Arrangements for the meeting to be held May 7-9, 1961 at the Mayo Hotel in Tulsa, will include several innovations, both in the scientific activities and the social events.

Ike Signs Health Care Bill For Aged

After three years of wrangling and countless legislative proposals, the U. S. Congress has agreed on a compromise bill designed to finance health care for persons over 65 years of age who are in need of such help. The final legislative outcome, H.R. 12580 (referred to as the Kerr bill), fell far short of the broad coverage contained in the much-ballyhooed Forand Bill (H.R. 4700) and thus escaped the veto power of President Eisenhower, who signed the measure into law on September 13. The new law, although it represents an amendment to Title I of the Social Security Act, does not in any way increase social security taxes. It becomes effective on October 1, 1960.

Benefits Outlined

Under the approved plan, states are permitted to enlarge their medical assistance programs for the aged, to include aged persons who are not old-age assistance recipients, but whose income and resources, as determined by the states, are insufficient to meet the costs of necessary medical services. In other words, federal-state matching funds will be available after October 1 to enlarge the scope of Oklahoma's present old-age assistance medical plan to the extent that "borderline" individuals who are *medically indigent*, but who do not otherwise qualify as welfare cases, may receive financial help with their medical bills.

States will be required to submit plans to the Secretary of Health, Education and Welfare for approval. The health program for "borderline" individuals *may* include the following, provided benefits do not exceed those offered to old-age assistance recipients: inpatient hospital services, medical, nursing, laboratory, x-ray, etc.; skilled nursing home service; out-patient services; organized home care services; private duty nursing service; therapeutic services; major dental treatment; laboratory and x-ray services; and drugs.

State plans must operate in all political subdivisions, must be administered by a single state agency and must have financial participation by the state.

Federal payments to states would be in the form of reimbursement for a portion of expenditures, according to the equalization formula now used to compute the Federal portion of old-age assistance payments. Federal participation will range from 50 to 80 per cent, based on the per capita income of the state. In Oklahoma's case, the Federal contribution will amount to about 68%.

Federal Funds for Welfare Recipients

In addition to providing for the *medically indigent*, the bill also enables Federal participation in existing medical programs for old-age assistance recipients. Thus, Oklahoma is expected to draw about $9 million annually from the Federal government to replace that amount which it is now paying for medical care for those on the public assistance rolls.

While the specific utilization of the financial windfall remains to be mapped out by the Oklahoma Department of Public Welfare, the Oklahoma Public Welfare Commission and other concerned officials, it is anticipated that some of the $9 million in state funds thus freed may be used to bolster or expand the public assistance program (medical and/or otherwsie) and the balance may be used to match Federal funds for the care of the *medically indigent* who are not on public assistance rolls.

There can be no reasonable estimate made of the number of persons who will fall into the *medically indigent* category until such time as the Oklahoma plan is finalized, specifically in regard to defining and qualifying the term "*medically indigent*."

Other Provisions

H.R. 12580 also increases appropriations in the areas of maternal and child health services, crippled children's services and child welfare services. Eligibility for disability benefits under O.A.S.I. was liberalized by eliminating age 50 as the eligibility point.

Attempts to use this bill to bring physicians into the Social Security program were stricken earlier by the Senate Finance Committee. Moreover, a provision to lower the O.A.S.I. retirement age for men (to

Oklahoma Hosts National Conference

The National Rehabilitation Association's annual Conference will be held in Oklahoma City, October 10-12, 1960, at the Biltmore Hotel. The General Session will be in the Warner Theater, with Mary Switzer, Director, Office of Vocational Rehabilitation, Washington, D.C. presiding.

Governor J. Howard Edmondson is slated to give the welcoming address. Senator Mike Monroney and Daniel Blain, M.D., Director, Department of Mental Health of California will also address the morning session.

Platform guests will include Senator Louis H. Ritzhaupt, M.D. and his Legislative Committee on Rehabilitation Services.

At 12 noon on the 10th, the Associated Industries of Oklahoma will sponsor a members luncheon. John Seaton, Secretary-Manager of the Pennsylvania Manufacturing Association will be a principal speaker at this event. Immediately following the luncheon, Kieffer Davis, M.D., Bartlesville, will join other national leaders in discussing policies in regard to hiring physically limited workers.

The afternoon session will also feature group discussions, such as Library and Library Services, The Role of the Church in Rehabilitation and Responsibility of Homemakers in Rehabilitation.

On October 11, the morning program will feature the Delegate Assembly and business of the Association. At 1:45 p.m., Sumner G. Whittier, Administrator of Veterans Affairs, Washington, D.C. will address the Conference. At 2:30 p.m., Total Evaluation in Rehabilitation will be discussed by Shelby G. Gamble, M.D., and others of the medical profession.

That evening, the Annual Conference banquet will be held in the Civic Room of the Biltmore Hotel. The principal speaker will be Frank Freemont Smith, M.D., Director, American Institute of Biological Science, New York City.

Wednesday, October 12, the morning session will be devoted to panel discussions. C. Esco Oberman, M.D., and Frederick A. Whitehouse, M.D., will participate in the panel discussion pertaining to Communications in Rehabilitation. Rehabilitation of the Senior Citizens will feature Kirk T. Mosely, M.D.; T. Glyne Williams, M.D.; James Overfelt and David Steen. Habilitation of the Mentally Retarded will be discussed by Gunnar Dybwad, M.D., Executive Director, National Association for the Mentally Retarded, New York City.

The Oklahoma State Medical Association's Committee on Rehabilitation, chaired by Earl McBride, M.D., will participate in the meeting by preparing an exhibit on "The Physician's Role in Rehabilitation."

Copies of the program may be obtained by contacting the Executive Office of the Oklahoma State Medical Association.

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62) was killed in a Senate-House Conference Committee.

Victory for Medicine

The passage of H.R. 12580 (estimated annual Federal cost: $300 million) and the ensuing defeat of an amendment on the floor of the Senate to offer complete health care to all Social Security beneficiaries (estimated annual Federal cost: $1 billion) represented a major victory for medicine, as well as for other organizations and individuals who have opposed the indiscriminate financing of health services for persons without proven need.

In contrast, the action represented a major defeat for the Democratic Party and its presidential candidate, Senator John F. Kennedy. The Democratic party had previously endorsed Forand-type legislation and Kennedy unsuccessfully championed this effort on the floor of the Senate.

Kerr's Contribution

Most prominent among the Senators who led the fight to defeat the Forand-type amendment was Senator Robert S. Kerr (D., Oklahoma). A few days before Congressional action was taken, Kerr met with representatives of the Oklahoma State Medical Association in Oklahoma City. During the heat of debate, he invited Oklahoma State Medical Association President Walter E. Brown, M.D., and Executive Secretary Dick Graham to Washington, D.C., to counsel with him regarding the real needs of Oklahoma's senior citizens.

Doctors' Aids May Improve Efficiency Through Training Courses

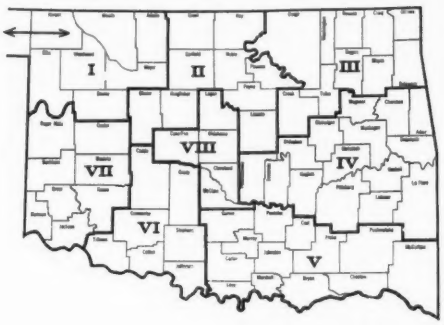
Two important educational events are shaping up for the medical assistants of Oklahoma this year. First, the University of Oklahoma Extension Division, cooperating with the state Medical Assistants society is offering for the second year, an eight week continuing education program designed specifically for the doctor's assistant. These programs which meet one night a week are called phases. With Phases I, II, III and IV developed (one semester each), this means the medical assistant has available to her, a two year education program of in-service training enabling her to better her professional status, increase her knowledge, and prove her value to her employer-physician. Basic subjects covered are medical backgrounds (history, terminology), business communications, human and public relations, office management, credit and collections, ethics, tax reporting, insurance forms, etc.

Phase I and II have been offered in Oklahoma City by the University, and Phase I has been given in Tulsa. Plans are being made to offer Phase III in Oklahoma City and Phase II in Tulsa this fall. The University is now working energetically with the state society to bring these same programs to various points in the state whereby it will be convenient for the Medical Assistant to participate although her time is limited. The present enrollment fee (based on the total expense for lecturers plus travel time, if any, divided by the number of enrollees) has been $25 for eight weeks. Past class experience has shown that in most instances the physician has been paying the enrollment fee for his medical assistant(s).

The Grass Roots Plan

The second of the two educational events is the statewide effort by the Medical Assistants Society of Oklahoma to bring *week-end* educational programs to *all* areas in Oklahoma. No matter how remote the assistant may be geographically, she will be offered the same educational material that all others are receiving in the more populated areas. To arrange this large undertaking, the society has divided the state into eight districts (Northwest, North Central, Northeast, East Central, Southeast, South Central, Southwest and Central).

EDUCATIONAL DISTRICTS, MEDICAL ASSISTANTS SOCIETY of OKLAHOMA



I Northwest District
II North Central District
III Northeast District
IV East Central District
V Southeast District
VI South Central District
VII Southwest District
VIII Central District

Each district will have an Educational Chairman and several vice-chairmen. Four meetings a year are planned for each District with the medical assistants in that district area participating. This will mean the week-end programs will be right in the medical assistant's hometown or nearby community. Registration fees will be modest to defray the expense of the meeting, and will decrease proportionately as enrollment increases. Programs established in this manner will afford the medical assistant convenience in driving distance, and the opportunity to increase her efficiency, to discuss in open-forum her every day problems with other persons in her field, and to gain a feeling of professional status.

Cooperation of M.D.'s Needed

In undertaking this large educational program for all of Oklahoma's Medical Assistants the state society will need the help and cooperation of *all* the physicians in the state to insure success. The University of Oklahoma is assisting in the programming of these meetings, and the OSMA Advisory Committee has approved them.

Plans Formulated for Oklahoma City Clinical Society

Plans are being completed for the Thirtieth Annual Fall Conference of the Oklahoma City Clinical Society to be held at the Biltmore Hotel, Oklahoma City, October 24, 25, and 26.

Fifteen guest lecturers from leading medical centers of the country will participate in general meetings as well as in the specialty lectures scheduled each morning and afternoon of the three-day meeting. The specialty sessions will consist of forty-five minute lectures followed by forty-five minute discussion periods.

Two roundtable luncheons will be held at noon each day, divided into medical and surgical groups. These luncheons will afford an opportunity for visiting physicians to meet and discuss individual problems with the guest speakers.

Furbay Featured Speaker

On Monday evening, October 24, the Oklahoma County Medical Society will be host at the annual banquet honoring the associate members and guest lecturers of the Oklahoma City Clinical Society. John H. Furbay, Ph. D., internationally known lecturer, author and world air commuter, will be the principal speaker of the evening.

On Tuesday evening, there will be specialty group dinners honoring the guest speakers. Those attending may select the group dinner of their choice.

Each year the Oklahoma City Chamber of Commerce honors the Oklahoma City Clinical Society members, their wives and guests with a dinner-dance. This event will be held on Wednesday evening in the Persian Room of the Skirvin Tower Hotel.

Upon recommendation of the Oklahoma Chapter of the American Academy of General Practice, the 1960 Fall Clinical Conference is acceptable for 12 hours of Category 1 Credit.

Guest Lecturers Named

In addition to Doctor Furbay, guest lectures will be: Robert P. Allen, M.D. (Radiology) Associate Clinical Professor of Radiology, University of Colorado School of Medicine, Denver, Colorado; Stuart W. Arhelger, M.D. (Surgery) Assistant Professor of Surgery, University of Minnesota Medical School, Minneapolis Minnesota; Don W. Chapman, M.D. (Medicine) Clinical Professor of Medicine, Baylor University College of Medicine, Houston, Texas; Wesley E. Compere, Jr., M.D. (Otolaryngology) Associate Professor of Surgery, (Otorhinolaryngology), University of Southern California School of Medicine, Los Angeles, California; Clifford F. Gastineau, M.D. (Medicine) Associate Professor of Medicine, University of Minnesota Graduate School, Rochester, Minnesota; Louis J. Girard, M.D. (Ophthalmology) Professor and Head, Division of Ophthalmology, Baylor University College of Medicine, Houston Texas;

Charles F. Gregory, M.D., (Orthopedic) Associate Professor of Surgery, Chairman Division of Orthopedic Surgery, University of Texas Southwestern Medical School, Dallas, Texas; Stanley F. Hampton, M.D. (Allergy) Assistant Professor of Clinical Medicine and Director of Allergy Clinic, Washington University School of Medicine, St. Louis, Missouri; Howard C. Hopps, M.D. (Pathology) Professor and Chairman, Department of Pathology, University of Texas-Medical Branch, Galveston, Texas; Howard W. Jones, Jr., M.D. (Gynecology) Associate Professor Gynecology, Johns Hopkins University School of Medicine, Baltimore, Maryland; Edward T. Krementz, M.D. (Surgery) Associate Professor of Surgery, Cancer Teaching Coordinator, Tulane University School of Medicine, New Orleans, Louisiana; Walter C. Lobitz, Jr., M.D. (Dermatology) Professor and Head, Division of Dermatology, University of Oregon Medical School, Portland, Oregon;

Theo C. Panos, M.D. (Pediatrics) Professor and Chairman, Department of Pediatrics, University of Arkansas Medical Center, Little Rock, Arkansas; E. H. Parsons, M.D. (Psychiatry) Assistant Clinical Professor of Neuropsychiatry, Washington University School of Medicine, St. Louis, Missouri; and Robert A. Ross, M.D. (Obstetrics) Professor and Chairman, Department of Obstetrics and Gynecology, University of North Carolina School of Medicine, Chapel Hill, North Carolina.

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1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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... swelling
... cleared
by fifth day[2]

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... resolved with
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rhus dermatitis
healed within
a week[1]

INFECTED
LACERATION
marked reversal
in 3 days...
returned
to school...
closure advanced[1]

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in a week after
recurrent episode[1]

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resumed after 4 days
of VARIDASE[1]

New Bill Provides Non-Service-Connected Out-Patient Care for Vets

In February 1955, the Hoover Commission's Task Force on Federal Medical Services recommended that Congress limit non-service-connected care to disabilities for which the need of medical treatment was established within three years after discharge and that out-patient care following hospitalization in these cases be authorized when medical need for such care was established at the time of admission. At that time, the Task Force estimated that such a restriction would save $150 million *annually*.

The Commission itself, feeling that such a time-limit on non-service-connected care would go against the general national sentiment, took up only the second portion of this recommendation, and suggested outpatient care, prior to and following hospitalization, for indigent veterans with non-service-connected disabilities. The Commission suggested that this would help minimize the demand for hospitalization.

The American Medical Association pointed out that dropping the three-year cut-off and adding out-patient care would lead to expansion of VA services, rather than the economy which the Commission was established to achieve; in June 1955, the House of Delegates noted that it agreed, in the main, with Task Force recommendations but could not agree with changes the Commission had made in these recommendations.

In the intervening years, the AMA and its Committee on Federal Medical Services have frequently pointed out the waste resulting from current methods in VA hospital care, whereby non-service-connected patients who would ordinarily be examined and their illnesses diagnosed in a doctor's office go through these procedures as in-patients, and veterans who could be convalescing at home remain in the hospital until completely restored. The medical profession has suggested, in solution, more emphasis on community care and less on the VA system.

This year there is a bill in Congress, already approved by the House Committee on Veterans' Affairs, which takes the opposite tack. H.R. 7965 introduced by Rep. Teague (D., Texas) would, for the first time, legally authorize out-patient care, at VA expense, for non-service-connected cases.

Present Out-Patient Program

The Veterans' Administration is, of course, already providing a considerable amount of out-patient care. In fiscal year 1958, over 2.1 million out-patients were provided with care, rehabilitation treatments, or various types of examinations—about 1.6 million by VA staff physicians and over half a million by private physicians, on a fee-for-service basis. (The actual number of individual patients and visits is not reported; an "out-patient" is defined as an individual receiving out-patient services one or more times during a given month, so that the total number of visits is almost certainly larger while the total number of veterans treated, allowing for those who made visits in more than one month, would be smaller.)

Legally, out-patient care is authorized for the treatment of service-connected disabilities and *any* disability of a Spanish-American War veteran is considered as service-connected for the purpose of providing out-patient treatment.

The VA also provides some out-patient convalescent care for non-service-connected cases through a legal fiction, "CBOC" (Continuation of Bed Occupancy for Convalescent Care). Under this system, the veteran is not officially discharged from the hospital rolls until his convalescence is complete, since non-service-connected care is authorized for hospitalized patients only, although he may be present only for out-patient treatment.

Text of Bill

The new bill, in its original form, authorized the Administrator of Veterans' Affairs to "furnish medical services for a non-service-connected disability" in three different instances: "in preparation for admission of a veteran for hospital care, . . . where such care is reasonably necessary in determining whether or not hospital care is needed . . . (or where) out-patient care is reasonably necessary to complete treatment incident to such hospital care."

In the final form, as voted on in Congress, the second provision was deleted, so that

out-patient care was authorized only for veterans scheduled for hospital admission and for those requiring convalescent care.

The American Medical Association has, of course, long held that care for civilian disabilities of veterans is not a legitimate Federal responsibility and that the laws should be changed to restrict VA care to service-connected cases; under present laws, it has recommended emphasis on financially catastrophic illness, rather than those requiring only short-term and less expensive care.

H.R. 7965 with its resultant expansion of the VA medical system, therefore runs directly contrary to the medical profession's recommendations.

As a matter of fact, even the Veterans' Administration took note of the fact that though this bill attempted to relate out-patient care only to hospital care, "it *might* be the opening wedge to further extension of this type of treatment."

VA Expansion

It is not merely a possibility, but a certainty that passage of this bill would lead to a considerable expansion of the VA medical care program, since it contains no provisions to keep care at the present level.

If merely the hospital facilities of the Veterans Administration are considered, such a bill might increase *efficiency*, since the VA would be authorized to provide on an out-patient basis any services for which hospitalization was not necessary; but it would also increase the feasible patient load.

For example, in calendar year 1957, there were 477,095 patients discharged from VA hospitals, with an average stay of 70.2 days. During the 1960 hearings of the House Veterans' Affairs Committee, the manager of one VA hospital estimated that such admission tests as urinalysis, blood counts, and screening X-ray take the doctors on the ward "2 or 3 days to get." If even this very minimal two-day reduction in the average stay were achieved throughout the VA hospital system, over *14 thousand* more veterans could be treated without adding to the total number of hospital days' care provided.

But this is only a seeming economy, since (as this same physician pointed out) present VA staffs could not handle the increased laboratory load. In other words, although the average stay would be shorter, the increased patient load would require more technicians, more paramedical personnel, and more physicians—merely to handle the increase in the annual patient load.

In fact, according to VA reports, only 33 of the existing VA out-patient clinics are directly connected with VA hospitals. The bill could well mean the addition of new out-patient departments at about 140 hospitals at present without them.

Nor would there be any total reduction in *hospital* costs, since the total bed occupancy would remain the same and the number of admissions would *increase*—with a concomitant increase in the number of in-hospital medical and surgical procedures, drug costs, and other factors which depend on the number of cases rather than of hospital days alone.

NSC Hometown Care?

It has already been noted that, even if only present VA facilities were used, this bill would lead to expanded staffing and expenditures. However, *the proposed out-patient care is not legally confined to VA facilities . . .* (although even the term "VA facilities" is defined, *by law*, to include the facilities of other government agencies and private facilities for which the Administrator contracts.)

Even this broad definition of "VA" facilities does not limit the outpatient care which this bill would provide—the language of the bill merely states that "The Administrator *may* also *furnish medical services* for a non-service-connected disability" for the two types of cases previously listed.

Since section 213 of the law already authorizes the Administrator to "enter into contracts or agreements with private or public agencies or persons, for such necessary services (including personal services) as he may deem practicable," the decision as to how and where these out-patient services would be provided is left entirely in the agency's hands.

Technologists Urged to Join Oklahoma Society

Since only 49% of eligible laboratory workers in Oklahoma belong to their professional organization, the Oklahoma Society of Medical Technologists is interested in increasing its membership.

The state society is an affiliate of the American Society of Medical Technologists. While the national group sets it own membership requirements (Master or Ph.D. degree from an accredited school and registered as a medical technologist with the American Society of Clinical Pathologists), it gives its state affiliates the power to establish local membership requirements.

Non-ASCP registered technicians may apply for associate memberships in the Oklahoma Society of Medical Technologists without having to meet the requirements of the A.S.M.T. The $4 annual dues entitle associate members to the state bulletin, published six times a year, a certificate of membership and attendance eligibility for all local and state seminars and conventions. Such members do not have voting privileges, however.

Dues for ASMT-OSMT membership are $16.00 per year. The Board of Registry of Medical Technologists of the American Society of Clinical Pathologists charges $20 for the qualifying examination.

Among the accomplishments of the affiliated state and national organizations are:

1. Professional classification for Civil Service employment.
2. Commissions in the Armed Forces.
3. Official opposition against unions.
4. Equal representation with pathologists on the Board of Registry and the Board of Schools.
5. Two national films: "Career-Medical Technology," and "The Human Cell and the Cytotechnologist."
6. ASCP Registry has the authority to give qualifying examinations for blood bank technologists.

Further information on membership may be obtained from Thomas B. Lamson, M.T. (ASCP) BB, Valley View Hospital, Ada, or from William F. Kidd, OSMT Treasurer, at the same address.

AAPS Will Meet in St. Louis

The Association of American Physicians and Surgeons will hold its 17th annual meeting at the Sheraton-Jefferson Hotel in St. Louis, September 29, 30, October 1, 1960.

Listed among the eminent speakers who will address the group are Edwin Vennard, Managing Director of the Edison Electric Institute, New York City; W. Cleon Skousen, author of "The Naked Communist," Salt Lake City; F. Gano Chance, President and Chairman, A.B. Chance Co., Centralia, Missouri; Doctor Sidney L. DeLove, President of Cook County Federal Savings, Chicago; Doctor Revilo P. Oliver, Professor of the Classics, University of Illinois; Robert Welch, Founder of John Birch Society, Belmont, Massachusetts; and Mal Rumph, M.D., AAPS Past President.

Featured speaker for the annual banquet will be the Honorable Barry Goldwater, United States Senator from Arizona.

Wives of attending physicians are urged to attend all speaking sessions with their husbands.

Programs may be obtained from the Association of American Physicians and Surgeons, 185 North Wabash Avenue, Chicago 1, Illinois.

AUA Offers Essay Prizes

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital internes and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Biltmore, Los Angeles, California, May 22-25, 1961.

Detailed information may be obtained by writing to Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be received before December 1, 1960.

Have You Heard?

JOEL W. ANDERSON, M.D., a graduate of Howard University School of Medicine, Washington, D.C., and former Okmulgeean, is joining the staff of the A. M. Stephens Clinic, 525 East Fifth Street in Okmulgee.

J. E. KING, M.D., a recent graduate of the University of Oklahoma School of Medicine, has established a clinic at 208 S.E. A Street in Stigler.

Oklahoma State Radiological Society officers are J. W. MURPHREE, M.D., Ponca City, President; SAM GLASSER, M.D., Oklahoma City, Vice-President; E. D. GREENBERGER, M.D., McAlester, Secretary; and SAMUEL POLLACK, M.D., Tulsa, Treasurer.

JOHN KIENZLE, M.D., recent graduate of the University of Oklahoma School of Medicine, has established a practice in Shawnee.

RALPH A. MCGILL, M.D., Tulsa, was honored by the American Cancer Society's Tulsa unit when he was named as the unit's first Honorary Life Member.

HENRY H. TURNER, M.D., Oklahoma City endocrinologist, attended the International Goiter Conference in London and the Congress of Endocrinology in Copenhagen during July.

GEORGE M. BROWN, JR., M.D., McAlester, was chief medical officer for the Oklahoma section of the Fifth National Boy Scout Jamboree held in Colorado Springs during July.

VICTOR HANSON, M.D., has recently established his practice in Weleetka. He is a graduate of the University of Oklahoma School of Medicine.

The Loy Clinic, Pawhuska, has announced that RICHARD F. HARPER, M.D., a graduate of the University of Oklahoma School of Medicine, is now associated with the clinic.

A 1959 graduate of the University of Oklahoma School of Medicine, MERLE CARTER, M.D., is now associated with CLAUDE WILLIAMS, M.D., at the Okeene Clinic.

R. A. CONLEY, M.D., a graduate of the University of Oklahoma School of Medicine last year, is a new member of the staff of the Watonga Clinic.

RICHARD B. JOHNSON, M.D., son of A.L. JOHNSON, M.D., El Reno, has joined his father in medical practice in El Reno.

DAVID O. CHILDERS, M.D., a native of Louisiana and graduate of the University of Oklahoma School of Medicine, has joined the staff of the Broadway Clinic in Shawnee.

MARSHALL INGRAM, M.D., a 1958 graduate of the University of Oklahoma School of Medicine, recently established his practice in Anadarko and is located at the Anadarko Clinic.

A native of Lawton, RONALD E. CAGLE, M.D., has joined the staff of the Bynum-Compton Clinic in Pryor where he will specialize in pediatrics. Since graduating from the University of Oklahoma School of Medicine, Doctor Cagle has completed residency training at Children's Memorial Hospital, Oklahoma City.

J. E. GRIFFIN, M.D., is a new staff member of the Bell Clinic in Tishomingo. A University of Oklahoma School of Medicine graduate, Doctor Griffin took residency training in general surgery at Hillcrest Medical Center in Tulsa.

DELBERT MCGINNIS, M.D., who was recently released from medical service with the Air Force, has established his practice in Oklahoma City.

JIM DUCKETT, M.D., who recently completed his residency in plastic surgery at St. Anthony's Hospital, is now associated with GEORGE KIMBALL, M.D., Oklahoma City.

Coming Meetings

Fourteenth Annual
SOUTHWEST REGIONAL CANCER CONFERENCE
Academy of Medicine
October 23, 1960 **Fort Worth, Texas**

John R. McDonald, M.D., pathologist, Harper Hospital, Detroit, Michigan; Juan Angel del Regato, M.D., radioligist, Penrose Cancer Hospital, Colorado Springs; and Bentley P. Colcock, M.D., surgeon, Lahey Clinic, Boston, will be guest lecturers for the Fourteenth Annual Southwest Regional Cancer Conference to be held in Fort Worth, October 23, 1960.

Further details may be obtained by writing to the American Cancer Society, Tarrant County Unit, Suite 111-115 Westchester House, 554 Summit, Fort Worth 2, Texas.

CLINICAL SYMPOSIUM
on
PEDIATRIC ONCOLOGY
November 11-12, 1960 **Houston, Texas**

The University of Texas Postgraduate School of Medicine and The University of Texas M.D. Anderson Hospital and Tumor Institute will co-sponsor a Clinical Symposium on Pediatric Oncology in Houston on November 11-12, 1960.

Important aspects of chemotherapy, surgery and radiotherapy in the management of children with various types of neoplastic disease will be covered.

For further information write to Office of the Dean, The University of Texas Postgraduate School of Medicine, 410 Jesse Jones Library Building, Texas Medical Center, Houston 25, Texas.

CORONARY ARTERY DISEASE
Nov. 28-Dec. 2, 1960 **Texas Medical Center**
Houston, Texas

The University of Texas Postgraduate School of Medicine will present a symposium on Coronary Artery Disease, November 28 through December 2, 1960 at the Texas Medical Center, Houston, Texas. Six guest lecturers, augmented by a local faculty, will present the program.

This five-day program has been approved by the Academy of General Practice for Category I Credit. No tuition will be charged unless physicians attending desire AAGP credit in which case a $5.00 registration fee will be required.

For further information write: Office of the Dean, University of Texas Postgraduate School of Medicine, 410 Jesse Jones Library Building, Texas Medical Center, Houston 25, Texas.

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS
September 29, 30 and October 1, 1960 **St. Louis, Missouri**
Shearton-Jefferson Hotel

The 17th Annual Meeting of the Assembly and Delegates of the Association of American Physicians and Surgeons will be held September 29, 30, October 1, 1960 at the Sheraton-Jefferson Hotel in St. Louis, Missouri. Further details may be obtained by writing to Louis S. Wegryn, M.D., President, AAPS, 185 North Wabash Avenue, Chicago 1, Illinois.

Southern Chapter
of the
AMERICAN COLLEGE OF CHEST PHYSICIANS
October 30-31, 1960 **St. Louis, Missouri**

The Southern Chapter of the American College of Chest Physicians will hold its 17th annual meeting at the Statler-Hilton Hotel in St. Louis, Missouri, October 30-31, 1960.

Further details may be obtained by writing the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

ASSOCIATION OF MILITARY SURGEONS
October 30-November 1, 1960 **Washington, D.C.**
Mayflower Hotel

The 67th Annual Convention of the Association of Military Surgeons will meet October 30, 31, November 1, 1960 at the Mayflower Hotel in Washington, D.C.

There is no registration fee for the session and reserve officers attending the meeting may register for credit points.

For detailed information, write to the Association of Military Surgeons, 1726 Eye Street, N.W., Washington 6. D.C.

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION
October 31-November 3, 1960 **Pittsburgh, Pennsylvania**
Pittsburgh Hilton Hotel

The 45th Scientific Assembly of the Interstate Postgraduate Medical Association will be held at the Pittsburgh Hilton Hotel in Pittsburgh, Pennsylvania October 31—November 3, 1960. The assembly is acceptable for a maximum of 16½ hours of Category 1 credit by the American Academy of General Practice.

Programs may be secured by writing to Roy T. Ragatz, Executive Director, P.O. Box 1109, Madison 1, Wisconsin.

Sixth Annual Meeting
AMERICAN RHINOLOGIC SOCIETY
October 8, 1960 **Chicago, Illinois**
Belmont Hotel

The American Rhinologic Society will hold its sixth annual meeting at the Belmont Hotel, Chicago, October 8, 1960.

No registration fee will be required and further information may be obtained by writing Robert M. Hansen, M.D., secretary, American Rhinologic Society, 1735 North Wheeler Avenue, Portland 17, Oregon.

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY
October 17-20, 1960 **University of Illinois College of Medicine**
Chicago, Illinois

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Broncheosophagology from October 17 through October 29, 1960, under the direction of Paul H. Holinger, M.D.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants may write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Book on Care of the Aged Now Available

The new Catholic Hospital Association publication on the care of the aged, "The Administration of Long-Term Care Facilities," is now available.

Sixteen recognized authorities in the field of geriatric care present material relating to the various aspects of care for the aged in an institutional setting. The papers also deal with problems of administration in such facilities.

The book is a collection of papers originally presented at an institute held in St. Cloud, Minnesota, sponsored by the Catholic Hospital Associaton of the United States and Canada and the Diocese of St. Cloud, which attracted attention of representatives from nursing homes in 15 states.

Price of the new publication is $1.50 each. Quantity prices are available on request from the Publications Department, Catholic Hospital Association, 1438 South Grand Blvd., St. Louis 4, Missouri.

Deaths

Loren Guy Blackmer, M.D.
1881-1960

Loren Guy Blackmer, M.D., pioneer Texas county physician, died in Hooker August 7, 1960.

A native of Albert Lea, Minnesota, Doctor Blackmer graduated from Illinois University College of Physicians and Surgeons in 1904. After practicing in Illinois and Colorado, he came to Oklahoma where he practiced in Guymon and Hooker.

In recognition of his years of service to the medical profession, Doctor Blackmer was awarded a Life Membership in the Oklahoma State Medical Association in 1957.

"Doctor Blackmer Day" was observed by the citizens of Hooker in 1956 when the townspeople set aside one day to honor him and express their gratitude for his devotion to the town and surrounding territory.

Albert N. Earnest, M.D.
1890-1960

Albert N. Earnest, M.D., a Muskogee physician since 1913, died at his home on July 27, 1960.

Born in Gore, Indian Territory, in 1890, Doctor Earnest graduated from the University of Tennessee School of Medicine in 1913.

Doctor Earnest spent two years with the Veterans Administration Hospital in Ashville, North Carolina, returning to Muskogee in 1934. He served as a Major in the Medical Corps during World War II.

Allen C. Kramer, M.D.
1900-1960

Allen C. Kramer, M.D., Tulsa surgeon, died August 19, 1960.

Born in Rockport, Indiana in 1900, Doctor Kramer had spent most of his life in Tulsa. He graduated from the University of Oklahoma School of Medicine in 1925. After practicing for six years in Ponca City, he returned to Tulsa and established his practice there.

From 1932 to 1936, he was Tulsa County health officer.

Auxiliary News

Bells Are Ringing

Many of the old truismatic drills we used in learning to type are applicable to this back-to-school and back-to-organization time of year. For example, now is the time for all good Auxiliary members to come to the aid of membership.

If the ground-work covered in one of our spring articles has been followed, even partially, now *is* the time to culminate your contacts, letters and telephone calls for new members. If you have not yet written letters, you may want to follow the example of one of our larger auxiliaries. The letter included: an invitation to join; the theme, *Preserve and Enhance American Medicine;* and an outline of the type of programming planned, together with social activities anticipated during the coming year. Such a letter provides the prospective member something tangible, a positive evaluation of the worth of the auxiliary program for her individual consideration.

Wish and Work

"Wish and work for what you want."—Most of us despised the short, jerky sentences included in practicing the "w's." But the wisdom of some of them becomes apparent. Membership, in the true sense, means not only gaining new members, but maintaining the active interest of doctors' wives who are already members. This goal is obviously not attained by wishes, but by work—the combined responsibility of the executive board and the individual members.

In some auxiliaries membership is so small that officers are automatically recruited—an unavoidable, yet regrettable circumstance. How can this be combatted? One young friend of mine accepted the presidency of an organization slowly declining in both membership and interest in this manner: "This is a time to be realistic. If we were a small corporation, convinced of the need and the worth of our product and services, we would do everything within our power to increase its worth. What I ask you to do can be accomplished quickly and reasonably: Let us all work together as if we were on salary, 'pushing for a raise,'—and sharing in corporation profits." Try it.

Health Careers

Do you also remember another old practice sentence?—"When a man plants a seed of corn, he does not go out the next day to look for a new stalk of corn." We can aptly apply this old truism to our Health Careers program. The normal seed planting time is early in the high school years; but if students have not been reached at all, the beginning of the senior year is perhaps the last opportunity we will have to plant the seed for Health Careers.

Every high school principal, counsellor or sponsor should have copies of *Careers in Nursing in Oklahoma.* This pamphlet outlines general information, accrediting and licensure, and lists accredited schools of nursing in our state. Early in the year an Auxiliary member should visit each Future Nurses' Club or Health Careers Club and explain our own State Nurse Loan Fund. (Some high schools are unaware of its existence.) Timing is of great importance; each year we lose many qualified students who can be encouraged toward Health Careers—and whom we can help financially. For additional information, contact our Health Careers Chairman (formerly Recruitment), Mrs. J. N. Owens, Jr., 8614 Waverly, Oklahoma City. Our Nurse Loan Fund Chairman is Mrs. E. C. Mohler, 731 Monument, Ponca City.

This is truly the time of year when every member can come to the aid of Auxiliary!

PHYSICIAN PLACEMENT

General Practice

Johnny Bill Delashaw, U.S.P.H.S. Hospital, Wyman Park Drive and 31st Street, Baltimore 11, Maryland, age 27, married, University of Texas Medical Branch, 1959, available July 1960.

John William Kennard, M.D., Blowing Rock Hospital, Blowing Rock, North Carolina; married; age 29; Bowman Gray School of Medicine, 1956; veteran; available August 29, 1960.

Robert D. McKay, M.D., Edgewood, Texas; Age 70; married; University of Illinois, 1907; available now.

Carle H. Schroff, M.D., 3811 State Line, Kansas City 11, Missouri: Age 31; married; University of Kansas, 1959; veteran; available August, 1960.

Internal Medicine

Jeanne B. Johnson, M.D., 4917 SE Cornell Drive, Bartlesville, Oklahoma; age 31; married; University of Oklahoma School of Medicine, 1955; specialty, internal medicine; eligible, immediately.

Thomas Turner Walton, Jr., M.D., 7375 Churchill, Detroit, Michigan: Age 29; married; Baylor College of Medicine, 1955; Board eligible; veteran; specialty, internal medicine; desires group or associate practice; eligible, July 1961.

Locum Tenens

Harold W. Calhoon, M.D., Wesley Hospital, Oklahoma City. One year residency in Internal Medicine. Available July 1 to September 15th, 1960.

Russell M. Preston, M.D., 476 San Juan, Oak Harbor, Washington, desires six month's work in General Practice between time of separation from military service to beginning of residency training, January-July, 1960.

Obstetrics and Gynecology

Gerald R. Keilson, M.D., Medical Arts Building, Dallas, Texas, age 31, married, University of Texas, 1953, board qualified, veteran, available in July 1960.

Juan C. Ruiz, M.D., 350 Park Ave., Lexington, Kentucky; age 36; married; University of San Marcos Medical School 1952; no military obligations; available July 1, 1960.

Robert B. Williams, M.D., 27 Normandy Road, Auburndale 66, Massachusetts; married; age 30; Tulane University, 1955; board certified; available July 1, 1961.

Orthopedics

Newsom Stool, M.D., c/o Mayo Clinic, Rochester, Minnesota; age 30; married; Baylor University 1953; Board eligible; available July 1960.

Urology

Alex Grossman, M.D., V.A. Center, Temple, Texas, 42, married, University of Texas, 1951, board certified, veteran, available now.

. . . yet ride a bike and ice skate, and have learned to roller skate, skip, and walk down the steps foot-over-foot."

Marion Phillips, school girl, began wearing a Hanger Hip Control Leg at the age of 10. The correct fit and dependable performance of her Hanger Leg have enabled Marion to take part in the normal activities of a teen-age girl. Her amazing rehabilitation is not unusual, others have been equally successful, and most Hanger wearers are able to return to a normal active life.

Hanger PROSTHESTS

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25 YEARS AGO

Articles published in *The Journal* of the Oklahoma State Medical Association, September, 1935.

ORAL ADMINISTRATION OF TYPHOID VACCINE

H. D. Moor, M.D., and Ida Lucille Brown, M.S.
Department of Bacteriology
University of Oklahoma Medical School
Preliminary Report

Since the establishment of the fundamental principles underlying the production of active acquired immunity by Pasteur in 1877, a variety of methods have been used such as intradermal, subcutaneous, intramuscular, intravenous and oral administration. Pasteur first used the oral method in immunizing fowls against chicken cholera. He fed them the attenuated organisms in their food and succeeded in immunizing them against this disease. We are all familiar with Calmette's B.C.G. Vaccine. This vaccine, however, is far from being established as a safe method.

Until the present year the Bacteriology department here has given little thought to the oral administration of vaccines of any kind. It was brought to our attention by one of our leading biological houses and we rather half-heartedly started to work with it. The results of our experiments have encouraged us to further investigate this problem. They confirm generally the findings of the majority of research workers with oral administration of typhoid vaccine.

No reaction resulted in any one of the ten vaccinated. This method used was a modification of Besredka's method. Bile was given with the first dose only. We intend using the original Besredka method with our next group.

A study of the protocol showing the results of our experiments reveals that the blood of those individuals who had been previously vaccinated by subcutaneous method showed a higher agglutinin titer six weeks after the administration of oral vaccine than did the blood of those who had had no previous vaccination.

The blood of all showed definitely the presence of agglutinins running from a titration of 1-160 to 1-1280. The agglutinating effect of an individual's blood on B Typhosus is now generally accepted as a measure of his resistance to typhoid fever.

The oral method of giving typhoid vaccine (as far as the results of our experiments go) produces a concentration of agglutinin antibodies greater than having typhoid fever does.

We hope to test out more extensively the value of this method of administering typhoid vaccine. If it is really as effective as the subcutaneous method it will mean a great saving in time and money to the State of Oklahoma, should they adopt it in the public health work.

MISCELLANEOUS ADVERTISEMENTS

FOR RENT: Available October 1, Clinic Building to accommodate one or two doctors. Excellent facilities. Long-established background. Located 318 West Commerce. Contact Miss Dining, ME 4-0573 or CE 6-5222.

WANTED: Surgeon to join old established group in town of 10,000 population in West Texas. Need not be Board certified but with adequate residency training. Write Key A, THE JOURNAL, Oklahoma State Medical Association, P.O. Box 9696, Oklahoma City, Oklahoma.

FOR RENT: Office space for two doctors. New air-conditioned clinic building. 1714 S. Midwest Blvd., Midwest City, Okla. Complete maintenance. Plenty of free parking for patients. Other two suites occupied by general practitioners. PE 2-4589.

WANTED: Internist to join old established group in town of 10,000 population in West Texas. Need not be Board certified but with adequate residency training. Write Key A, THE JOURNAL, Oklahoma State Medical Association, P.O. Box 9696, Oklahoma City, Oklahoma.

PHYSICIAN for Ramona, Oklahoma, growing ranch-farm community, over 1,000 trade area, 35 miles from Tulsa. Will build. Bring family, visit. Merle Smith, President, Ramona Medical Building.

FOR RENT IN TULSA: Suite of four rooms in clinic with two doctors and a dentist. Mrs. L. C. Northrup, 1828 E. 32nd Place, Tulsa, Oklahoma.

FOR SALE: Burdick EK 111 ECG; Hamilton, coral colored examining table; Castle Autoclave. All are practically new and are reasonably priced. Jeanne B. Johnson, M.D., 4917 E. Cornell, Bartlesville, Oklahoma.

FULLY EQUIPPED general practice office and x-ray practice immediately available. May be purchased with the income from the practice. Ideal for internist or generalist. Call WE 6-9453 or write John C. Kramer, M.D., 1547 South Lewis, Tulsa 4, Oklahoma.